STATE TITLE V BLOCK GRANT NARRATIVE
STATE: NM
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The Assurances and Certifications are in pdf format in an attachment to the New Mexico Title V Grant Annual Report and Application. The central office of the New Mexico Title V MCH Program also maintains a reference copy. on file in the State MCH program's central office and will be made available upon request. If you would like to request copies, please call the Family Health Bureau Chief at 505-476-8901

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

/2006/ Upon receiving final approval for the FY06 Application from the MCH Bureau/ HRSA/ DHHS the New Mexico Department of Health will publish a notice in the Albuquerque Journal, which has statewide distribution, inviting the public to comment on the current Title V Block Grant. It will be available to the public for review through contacts at each of the four district offices of the Public Health Division located in Santa Fe, Albuquerque, Las Cruces and Roswell, and the Title V State Office in Santa Fe. The Title V State Director will consider public comments on the Block Grant for a specified period of thirty days. The Title V State Office will acknowledge comments, and the Family Health Bureau (FHB) Management Team will review summary of comments and follow up on critical issues. The FHB Management Team will consider comments when evaluating program services and developing the subsequent year's Block Grant.

Public Input is an ongoing process. Input for DOH priorities was solicited through the revision of the DOH strategic plan process and the development of a comprehensive MCH Assessment. Input from advisory groups was ongoing and is featured in this report and application document: the State's Early Childhood Comprehensive Systems (ECCS) working groups, the Children's Cabinet, the Children & Youth with Special Health Care Needs (CYSHCN) Transition Planning Council, the Youth Development Advisory Councils, the PRAMS Steering Committee, Family Health Bureau consultant./2006

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

PART III. STATE OVERVIEW

PRINCIPAL CHARACTERISTICS AND THE HEALTH NEEDS OF NEW MEXICO'S MCH POPULATION

New Mexico was the 20th fastest growing state between 2000-2003. In 2003 New Mexico ranked sixth lowest in population density at 15.4 persons per square mile and fifth in size at 121,365 square miles. The total population was estimated at 1,874,614 persons, a 3.1% increase since 2000 and 0.64% of the total U.S. population. New Mexico remains a young state with 30% of the population under age 20, compared to 28.1% for the U.S; an estimated 12% was over age 65, compared to 12.3% for the U.S.

New Mexico Population Density, 2003:

There are 33 counties in the state to which reference will be made throughout this document. The map shown here depicts population density: only 8 of the 33 counties had a density greater than 14.2 persons per square mile. The state has borders with Arizona to the west including a common territory with the large Navajo Nation in the northwest corner; Colorado to the north; Texas to the east and the southern edge to the hook on Dona Ana County; and a common border with Mexico in the southwestern corner.

New Mexico became a "minority majority" state in 2000, with the combined Hispanic, Native American, Asian and African American population being greater than non-Hispanic Whites. There were significant differences in many health and social indicators between racial and ethnic groups; the NM Department of Health (DOH) has made significant strides in assuring that policies and programs be culturally competent. According to 2003 population estimates, 85.6% of New Mexicans were white (includes individuals of Hispanic origin), 2.5% were Black, 10.3% were American Indian and 1.55 were Asian or Pacific Islander. Hispanics made up 43.2% of the population; non-Hispanics 56.8%. An estimated 67% of N.M. children and 55% of adults were of a minority group. Nearly 55% of the state's children were Hispanic, the highest proportion of any state.

In 2003 the racial distribution of children is shown below; a greater proportion of the 0-2 year old population was of minority group than subsequent age sets; The majority of white children were Hispanic.

Source: National Survey of Children's Health, 2003; Analysis by MCH Epi NM, Stata v.7

The second graph shows that 54.4% of children were of Hispanic origin; 45/1% were not. The majority of these children were categorized as White race in the table above.

Source: National Survey of Children's Health, 2003; Analysis by MCH Epi NM, Stata v.7

Among females 67% of the population was of a minority group. Lower proportions in higher age groups among Black and American Indian suggests higher mortality rates in these two populations.

Source: NM Intercensal Estimate, BBER/UNM 2003

An estimated 20% of NM children were born of immigrant parents. Sources other than the National Survey of Children's Health (NSCH) document that the majority of NM immigrants are of Hispanic origin.

Source: National Survey of Children's Health, 2003; Analysis by MCH Epi NM, Stata v.7

NATIVITY AND LANGUAGE: Ten percent of the people living in New Mexico in 2003 were foreign born. Ninety percent were native, including 56 percent who were born in New Mexico.

Among people at least five years old living in New Mexico in 2003, 36 percent spoke a language other than English at home. Of those speaking a language other than English at home, 78 percent spoke Spanish and 22 percent spoke some other language; 31 percent reported that they did not speak English "very well." American Community Survey, US Census, 2003 www.census.gov/acs.

Children of immigrants are the fasted growing part of the U.S. population. According to the Urban Institute, in 2000, Immigrants were 11% of the US population; children of immigrants made up 22% of the population of children under age 6 in the US; and 93% of children of immigrants under age 6 are citizens. Most live in mixed status families. Legal and undocumented parents may be reluctant to approach publicly funded services despite their child's eligibility based on birth. Many of these children live in families with low incomes, have parents with low education level and limited English proficiency, and interact less often with their parents. These factors may be associated with poor school performance by the children. Young children of immigrants are substantially more likely to be poor and to experience food and house related hardship -- 56% as compared to 40% of young children of natives. Children of immigrants are more likely to have fair or poor health and to lack health insurance or a usual source of care. Children of immigrants are more often in parental care and less often in center-based care. Yet center-based child care may benefit a child's early development (The Health and Well Being of Young Children of Immigrants by Randy Capps, Michael Fix, Jason Ost, Jane-Reardon-Anderson and Jeffrey S. Passel, Urban Institute, 2004; report available at www.urban.org.)

SOCIO-DEMOGRAPHICS AFFECTING MCH WELL-BEING: Family structure is associated with child health, while cultural variations such as extended families or the ways in which social networks support children and parenting are not reflected in official statistics. US Census 2000 data for NM reported that 63% of NM children lived in two-parent households; an estimated 8% of children lived in single father families; an estimated 22% of children lived in single mother families; and 6% of children were reported to live with grandparents or other relatives. In 2003, 48.5% of NM births were to single mothers, more than doubling from the 1982 figure of 22.1%; and greater than the estimated 34% for the nation in 2002. Significant differences were reported between racial-ethnic groups and age groups. Between 2002-2003 the marriage rate decreased from 7.9 to 6.9 marriages per 1,000 population and the divorce rate decreased from 4.4 to 3.4 divorces per 1,000 population. Both rates were lower than U.S. rates.

The Burdens of Poverty: In 2003, NM ranked 46th in per capita personal income at $25,502, which was 81.1% of the national average. The state's poverty rate remains one of the highest in the nation. In 2003 an estimated 18.6% of the NM population lived below 100% of the federal poverty level (FPL) compared to 12.7% of the US population. Significant disparities were reported for racial-ethnic groups: 31.6% for Blacks; 30.6% for Native Americans; 24% for people of Hispanic origin; and 16.4% for Whites. For many years New Mexico has ranked among the four worst states for the proportion of children living £100% FPL and of low income children £200% FPL. In 2000, an estimated 11% or 57,000 of the state's children lived in deep poverty, at or below 50% of the FPL. To place these data in perspective, a family of 3 persons with an income of $15,670 was <100% FPL. In 2002, the percent of children living at or below poverty varied from 44.3% in McKinley County to 2.6% in Los Alamos County. All but 11/33 of the counties reported a higher rate of childhood poverty than the state average of 25.2.

In 2003 an estimated 24.5% of New Mexico's children lived in poverty compared to 17.8% in the U.S. The NM percent of near-poor families below 200% of poverty was 1.3 times that of the U.S. By contrast, the US had a higher proportion of higher income families than NM.

Source: Child and Adolescent Health Measurement Initiative (2005). National Survey of Source: Children's Health, Data Resource Center on Source: Child & Adolescent Health website. Retrieved June 2005 from www.nschdata.org.

Title V MCH programs and its MCH partners strive to address the high rate of poverty in the state and the disproportionate burden of coping with less social advantage, particularly among minority groups who make up, indeed, the majority of this population. Gaps and disparities are seen consistently among teens, parents with only a high school education or less, and single parents. These characteristics translate into greater proportions of health risk behaviors, and lower access to and use of primary preventive care or specialty care. Although the state has made progress in reducing the

proportion of the population that has no health insurance, critical gaps persist. There is a significant challenge in assuring access to care for the working poor and immigrant families who come into the state -- many who pay taxes on their income.

There were significant disparities within 2003 poverty data that have implications for MCH policies and programs. Comparing NM to the US, the proportion of these segments of the population lived at or below 100% FPL (www.statehealthfacts.kff.org),:
v 27% of NM adults with children v. 19% for the US
v 23% of NM females v. 18% of NM males; 16% of US females v. 14% of US males
v 20% of people living in NM metropolitan areas; 28% in non-metropolitan areas.
EDUCATION: In 2003, NM ranked 46th of 50 states in high school graduation rates. In 2003, 80 percent of people 25 years and over had at least graduated from high school and 24 percent had a bachelor's degree or higher. Nearly 20% of the population had less than a 12th grade education; 27.39% were high school graduates. The three key dimensions of health: health outcomes, health behaviors and access to/use of health services are all related to educational levels in NM. This has been well documented for mothers of live born infants since 1997 from the NM Pregnancy Risk Assessment Monitoring System (PRAMS) and for adults over 18 years of age in the NM Behavioral Risk Factor Surveillance System (BRFSS).
Among people 16 to 19 years old, 10 percent were dropouts; they were not enrolled in school and had not graduated from high school. The total school enrollment in New Mexico was 515,000 in 2003. Preprimary school enrollment was 55,000 and elementary or high school enrollment was 338,000 children. College enrollment was 122,000. American Community Survey, US Census, 2003 www.census.gov/acs.
Employment: Unemployment is a critical issue for New Mexico. In 2000, the NM unemployment rate was 4.8%; and in 2005 it was 6%. In 2003, an estimated 70% of NM households had at least one full-time worker v. 73% in the US; 9% were part-time in NM v. 7% in the US; and 21% were households with no employed persons in NM v. 19% in the US. The impact of unemployment on families and children is significant, not only for the stark experience of being unemployed but also for the emotional stress it places on parents.

Use of Welfare to Work Program and the Food Stamp Program: While over 24% of families with children lived =100% FPL, less than ¼ of poverty level households had a member who actually used the TANF or cash assistance programs:

Source: National Survey of Children's Health, 2003; Analysis by MCH Epi NM, Stata v.7
In NM in June 2004 there were 17,000 cases comprising 43,736 individuals, 16,029 adults and 27,624 children in the Temporary Assistance to Needy Families (TANF) program. Participants must be needy by state eligibility ($12,732/year for family of 3); and must participate in work activities after 24 months (they can attend school up to 24 months). Expenditures totaled $5.3 million that was a --0.5% decrease from the previous year.
While NM families and pregnant women have relatively high rates of food insecurity compared to the nation, just over 1/2 of poverty level households had a member who actually used the food stamp program.

Source: National Survey of Children's Health, 2003; Analysis by MCH Epi NM, Stata v.7
In June 2004 there were 88,499 cases, 48.4% were adults and 51.6% were children; the majority or 58.4% were Hispanic followed by 24.7% White, 13.6% Native American.
Geographic Distribution of the Population: There are 33 counties in NM: 14 are frontier or sparsely populated having only 8% of the population; 9 are rural areas with 34% of the population; 3 are urban areas with 11% of the population (Los Alamos, Sandoval and Valencia); and 3 are metropolitan areas with close to half of the population (Bernalillo county with Albuquerque, Santa Fe and Dona Ana with Las Cruces).

This population distribution is characteristic of the large, mountainous states in the Rocky Mountain West, and presents unique challenges to provision of primary preventive care and specialty care.

Issues of Access to Health Care: Many counties of NM have gaps in critical services for primary care, dental care and mental health care. Using 2002 federal designations of Health Professional Shortage Areas (HPSA), 28 of 33 counties were HPSA for primary care; all but nine for dental care; and all but four for mental health care. In 2004, new definitions were introduced making comparisons somewhat difficult. Large proportions of the state remained HPSA qualified in all three categories. Detailed maps were published in 2005 by the NM Health Policy Commission and are found at www.hpc.state.nm.us. Specialty services are found primarily in the Albuquerque area, the location of the only two perinatal specialty hospitals in the state; one specialty hospital for children and youth with special health care needs (CYSHCN); and the majority of specialists in the state.

HEALTH CARE WORKFORCE ISSUES

From a summary prepared by the NM Health Policy Commission, three major factors contribute to the workforce environment: high poverty levels, a largely government based economy and demographic changes. The latter refers to the out-migration of people with college degrees and in-migration of those with less than high school education.

Retaining health professionals has these issues or outside competition:

v low reimbursement rates by Medicaid and Medicare coupled with high levels of Medicaid and Medicare enrollment

v poor work environment, especially in frontier and rural sites

v large rural stretches and rural areas that do not have socio-cultural amenities for a family

v minimal professional interaction -- in rural and frontier areas.

Out of 4,231 physicians in New Mexico the 2000 racial ethnic distribution of licensed physicians was out of sync with the population's racial-ethnic distribution. Only 7% were Hispanic while an estimated 50% of NM children were Hispanic; and 0.4% were Native American while ~13% of children are Native American. Finally, an estimated 60% were white, non Hispanic, 1.1% were African American, 4.7% Asian American and the rest were unknown.

Several initiatives were in place in 2004-05 to recruit and retain health care professionals for New Mexico. These include the J-1 Visa Waiver Program; the NM Health Service Corps; a Specialty Extension Services program, Locum Tenens, Health Loan-for-Service, Loan repayment program, and the Western Interstate Commission on Higher Education (WICHE) and Baylor Dentistry Programs.

The above section was abstracted from the NM QuickFacts, the annual reports of the NM Health Policy Commission: www.hpc.state.nm.us.

HEALTH INSURANCE COVERAGE IN NEW MEXICO: In 2003, an estimated 414,000 New Mexicans (22%) did not have health insurance; 70 percent of the uninsured were working people; and only 50 percent of small employers (under 50 employees) offered employer sponsored insurance plans.

The NM Health Policy Commission, 2005 Quick Facts, summarized key issues that characterize health insurance coverage: In 2003,

v 48.9% of New Mexicans had insurance coverage through an employer compared to 60.4% nationally.

v 19.3% of New Mexicans were covered by Medicaid and 15% by Medicare, compared to 12.4% Medicaid and 13.7% Medicare in the United States.

v Military coverage insured 4.8% of New Mexicans compared to 3.5% nationally.

v Using a three-year average, New Mexico had the second highest proportion (21.3%) of uninsured population in the nation (Texas had 24.6% and the best performer, Minnesota had only 8.2% uninsured).

v In 2004 the state's uninsured population nearly matched the number of Medicaid enrollees: 414,000 uninsured and 420,145 on Medicaid.

NM ranked among the worst five states for the highest proportion of children living at or below the federal poverty level (FPL) for many years. Thus it is no surprise to see that there are 1.4 times as many NM children at or below 200% of poverty than in the nation. What is interesting is that the proportion of uninsured children in the nation was 7.5% and did not change for period 1999-2003. On the other hand, while poverty levels remained high in NM, the proportion of uninsured children decreased about 50% from 15.1% in period 1999-2001 to 7.5% in 2001-2003. In real numbers, in the five year period of time, an estimated 27,000 fewer children were uninsured (81,000 in 1999-2001 period to 54,000 in the 2001-2003 period).

The Medicaid reports of June 2001-2004 indicated an average annual percent increase in children enrolled of 6.6%. In June 2001 there were 223,290 children enrolled; in June 2003 the number was 260,500; an increase of 37,000 children. (Monthly Statistical Reports, NM HSD).

In 2003, the National Survey of Children's Health (NSCH) that found 9.6% or 48,134 New Mexico children age 0-17 had no insurance as compared to 8.8% of US children.

While the proportion of low-income and very poor children <200% of poverty in New Mexico has not changed in over 10 years, it does appear that fewer of these children are uninsured -- and hence, have access to health care.

The NSCH reported key differences in having any form of health insurance. While the NSCH does not provide more localized data -- such as by county or public health district -- it does describe disparities in coverage by age group.

Percent of Children with Any Form of Health Insurance,by Age Groups, NM 2003, from National Survey of Childen's Health

Age Chiild	No	Yes	Don't Know
0-2 years	10.8%	89.2%	0.0%
3-5 years	6.1%	93.9%	0.0%
6-9 years	9.8%	90.2%	0.0%
10-13 years	11.1%	88.4%	0.5%
14-17 years	9.5%	90.5%	0.0%
All children 0-17 years	9.6%	90.3%	0.1%

Disparities in coverage by race and ethnicity, and uninsured included
v 7% or 11,300 White children
v 10.2% or 25,330 Hispanic children, a rate that was 1.4 times White children
v 12.2% or 983 Black children
v 14.5% or 9,000 Other children - in the New Mexico sample of the NSCH this group included Native Americans. The rate was 2.1 times that for White Children. It would seem that Native American respondents in this group -- all of whom are eligible for Indian Health Services -- did not consider I.H.S. to be a form of coverage in this survey.

Nearly half of NM children were covered by Medicaid or the state Children's Health Insurance Program (S-CHIP). An estimated 46.9% of all children were covered by Medicaid or the state child health insurance program (S-CHIP); and 52.4% had some other forms of coverage (health insurance, pre-paid plans such as HMOs).

An estimated 16.9% of NM children age 0-17 were currently uninsured or not covered for some period of time in past year compared to the US figure of 14.9%.

Of NM children who had current coverage, 7.96% reported gaps in coverage. An additional 9.6% had no coverage at all. This figure approximates the national report of NM data (16.9%).

Those whose coverage was Medicaid had 2.24 times the risk of not being covered at some time in the past year compared to those with other forms of coverage (RR 2.24,). This data was collected in 2003, before Medicaid instituted rules that required re-certification for eligibility every six months. It is thought that the risk of gaps increased during 2004-05.

Disparities in insurance in NM for 2003 were reported in the NSCH 2003; more analysis is needed to understand these data and their implications for policy or program initiatives:

Children of parents not born in the US, and children not born in the US were more likely to not have current health insurance in 2003. See section on immigrant health.

Between 11-14% of NM children age 0-17 were potentially eligible for Medicaid (<185% FPL) or S-CHIP (185-235% FPL) and were not covered by any form of health insurance.

In summation, it appears that child health insurance coverage has improved and may still be improving as this report goes to press. Some of the key issues regarding health insurance coverage are known to persist (abstracted from Who's Uninsured in New Mexico and Why? www.familiesusa.org) and from qualitative information gleaned during the needs assessment exercise):

v Employer-based coverage for those who work in small businesses continues to be unaffordable for the business or the employee. About 23% of New Mexicans worked for small employers in 2000.
v Service and labor jobs are less likely to provide insurance; about 63% of uninsured workers hold such jobs, although they make up only 40% of the workforce.
v Part-time workers are often not eligible, thus their children are affected.
v Low wage workers are often not able to afford health insurance offered by the employer.
v People who lose their jobs often lose health insurance; the unemployment rate in NM went from 4.8% in 1999 to over 6% in April 2005.
v People --including children- with any pre-existing condition have to pay significantly more for private insurance or may not be able to afford it at all.
v Keeping current is a challenge -- families who lost work or have decline in income may not be aware they qualify for Medicaid or S-CHIP.
v The present 2005 policy to require re-certification every 6 months may begin to show up in the data as a gap in coverage, or no coverage for those who may be discouraged by the paperwork involved.
v Immigration status imposes a 5-year delay from time of legal entry to the US for children to apply for Medicaid or S-CHIP. Citizen children living in immigrant families are eligible for Medicaid/S-CHIP but may not enroll because of parents' language barriers, confusion about eligibility and program rules and fear of repercussions for using public benefits (cited in Future of Children 2003 as well as direct observation by NM public health staff)
v Language barriers cause confusion about eligibility and program rules and in the case of immigrants fear of repercussions for using public benefits
v The increasing cost of medical care and hospitalization is a risk because it discourages providers from accepting Medicaid children and families.

Finally, the NSCH reported on the percent of children who had coverage for dental care. The proportion who had some coverage for dental care is less than the proportion of children who had some form of health insurance, it is the first time such data has been available so there are no trends. While over 70% of children had coverage, there are real gaps in access. There are still too few dentists who accept Medicaid, and children in smaller communities may have to travel over 100 miles to reach a dentist.

Medicaid and the State Child Health Insurance Program (S-CHIP)

A report on Medicaid by the NM Health Policy Commission, 2005 Quick Facts, summarized key issues impacting NM Medicaid: "The 2004 state legislature required Medicaid to reduce spending by $40 million beginning on July 1, 2004 in order to stay within the $475 million budget (state share) set by the legislature. On July 1, 2004, New Mexico Medicaid implemented a cost containment program that is expected to save an estimated $6 million by reducing provider reimbursements by 1.5%. Physicians, practitioners and other service providers were affected including, hospice, waiver services, treatment foster care providers, dental services, case management, early intervention, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening, inpatient hospital services

(in-state general acute hospitals and border area hospitals), outpatient hospital services such as laboratory services; dialysis services; and ambulatory surgical centers (Notice of Reduction in Medicaid Payments www.state.nm.us/HSD. On July 1, 2004, New Mexico Medicaid implemented changes in client eligibility certification. Children's Medicaid eligibility periods changed from one year to six months and pregnancy and family planning eligibility changed from two years to one year. Continuous eligibility has been removed and clients are required to report increases in income as soon as they happen. A cost sharing initiative is in process and expected to be implemented in 2005 as recommended by the Medicaid Reform Committee and required by legislation passed in the 2003 Legislative Session. This initiative may include co-payments, enrollment fees and minimal premiums.
As of July 2004, the New Mexico Human Services Department reported 420,145 New Mexican enrollees in Medicaid, about 22.41% of the state population. 268,734 (63.96%) of enrollees are children. The Federal Matching Rate for New Mexico Medicaid has decreased from 78% in Fiscal Year 2004 to 74% in FY 2005. In FY 2004, the federal government paid 77.8 cents of every dollar spent on the basic Medicaid program in New Mexico; in FY 2004, 74.3 cents. Over 15,500 providers participate in the Medicaid program in New Mexico.
Although the number of children under 21 years of age enrolled in Medicaid has steadily increased since 2002, children as a percentage of the total enrollment in Medicaid has decreased from 66.47% in 2002 to 63.96% in 2003."
New Mexico has 34 eligibility categories that include individuals receiving Supplemental Security Income (SSI); families in the Temporary Assistance to Needy Families (TANF) program; poverty level women and children; and persons residing in long term care facilities. Pregnant women and children £185% FPL are eligible for Medicaid; children between 185%-200% are eligible for S-CHIP; women £185% FPL are eligible for the 1115 Medicaid waiver for family planning services. Other eligibility criteria are found in the Needs Assessment attachment. NM eligibility criteria do not follow the usual published figures for the population by Federal Poverty Levels.
INDIAN HEALTH: POPULATION, HEALTH SERVICES AND TRIBAL HEALTH ENTITIES
An estimated 12.3% of the 2003 NM population were members of 22 tribal entities (although note that not all tribal members reside within a federal tribal area:
v Apache at Jicarilla in the North East and Mescalero in the South Central part of the state
v Navajo in the NW corridor along the NM -- Arizona border
v Eight Northern Pueblos-- Nambe, Picuris, Pojoaque, San Ildefonso, San Juan, Santa Clara, Taos and Tesuque
v Eleven central area Pueblos - Acoma, Isleta, Jemez, Laguna, San Felipe, Sandia, Santa Ana, Santo Domingo, Ysleta Del Sur, Zia and Zuni
Health care for tribal members is available through Navajo Area Indian Health Service (I.H.S.) with units at Gallup, Crownpoint and Shiprock; the Albuquerque Area I.H.S. with units at Albuquerque and Santa Fe. Hospital discharge data for NM does not include I.H.S. or tribal hospitals.
Tribal WIC programs are organized to serve the Eight Northern Pueblos, Isleta, Zuni, Five Sandoval, Santo Domingo, San Felipe and Acoma-Canoncito-Laguna areas. Note that NM WIC program data includes Mescalero, Alamo, Jicarilla Apache and First Nations in Albuquerque but not the other large tribal WIC entities. Population-based information about WIC clients is produced by NM Pregnancy Risk Assessment Monitoring System for mothers and infants up to age 9 weeks.
There are several initiatives of collaboration between the DOH and tribal or I.H.S. that serve to assure Native American needs are incorporated into the state public health community:
v The Native American Data Advisory Working Group (NADAWG) that began about 5 years ago and has been formalized with a staff person in the Epidemiology & Response Division (ERD) of the NM DOH. This group strives to share public health data projects -- surveillance, monitoring, evaluation, research -- as a form of data to action, and collaborative sharing.
v The County Health Council initiative includes four tribal councils: ToHa'jiilee within Navajo territory; and Acoma, Cochiti and San Ildefonso pueblos.
v NM Vital Records and Health Statistics produces a Tribal Report of birth and death data -- the most recent edition covered 1995-1997. This report is available at www.health.state.nm.us.
HEALTH CARE COVERAGE AND ELEMENTS OF THE NM SAFETY NET
Some of the NM population has no health insurance coverage for a variety of reasons including but not limited to immigrant status and employment without insurance coverage. The safety net for direct health services is comprised of the following:

v County Indigent Funds: each county has specific critieria for eligibility; in the 2005 needs assessment, county level public health professionals cited the difficulties for families who may move from one county to another
v State General Fund, Healthier Kids Fund: this fund, $800,000 in 2004, is administered by Children's Medical Services (CMS) and purchases services for primary care needs of children who have no possible source of coverage.
v Title V MCH Block Grant, Children's Medical Services (CMS): funds are used to procure high risk insurance for children who have no coverage, and who have serious conditions requiring specialty care.
v Title V MCH Block Grant, High Risk Prenatal Fund: funds are used directly and cover prenatal and delivery costs for women at high risk and have no possible source of coverage.
v NM Department of Health, MCH Services in Local Health Offices: selected MCH services are offered in areas where there are no prenatal or well child providers; case management for children with special health care needs and family planning clinical services are offered in every county; registration does not include residential status, and DOH policy forbids denial of service based on race, ethnicity, age, sexual orientation or other potential reasons for a person to feel marginalized or the object of discrimination.
v MCH Services in Federally Qualified Health Centers and Community Health Centers: limited MCH services, particularly prenatal care, is offered due to provider preferences and training and costs of malpractice insurance.
COUNTY HEALTH COUNCIL PRIORITIES IN 2005
In 2005, each of the 33 counties of NM had a County Health Council (CHC); four of them were newly created in working on council development including needs assessment and setting priorities. There are four Tribal Health Councils at Acoma, ToHa'jiliiee, Cochiti and San Ildefonso. They included Harding and Union in the northeastern corner and Lea and Roosevelt in the southeastern corner of the state. While many counties had core funding from the County MCH Act and its state general fund mechanism, additional funding streams were added. A more detailed analysis of the CHC and Tribal Health Council Plans will be done in 2005-06 to examine the degree to which strategies and interventions actually target the MCH population. There is high potential for the CHCs to contribute to progress in key MCH outcomes and the health and wellbeing of the 0-3 year old population.
Counties with core MCH priorities included the following Counties with more general DOH Priorities included the following
Breastfeeding = 1 (Colfax)Family strength = 2 (Grant and Torrance)Home visiting = 1 (Santa Fe) Immunizations = 1 (Colfax)Low birthweight = 2 (Colfax and Rio Arriba)Teen Pregnancy = 17 of 33 countiesViolence-Abuse = 7 countiesYouth violence and crime = 3 (Eddy, Los Alamos and Taos) Access to continuum of care = 9 of 33 countiesBehavioral Mental Health = 3 (Cibola, Colfax, Rio Arriba)Diabetes = 1 (Colfax) and 4 tribal health councilsObesity = 10/33 countiesEconomic Development = 2 (Grant and Hidalgo)Heart disease = 1 (Hidalgo)Suicide = 3 (Cibola, Colfax and Rio Arriba)Substance Abuse = 19 of 33 counties and 2/4 tribal councilsTransportation = 1 (Sierra)
The health status of all New Mexicans and of the MCH population is extremely challenged by the profile of poverty and other forms of social disadvantage and health risk. When compared to the nation, the state ranks poorly. The United Health Foundation report revealed that NM ranked at 50th or 49th for four out of nine indicators. The report stated that until the issues of poverty and education are improved, the work of the state's safety net will continue unabated. While dollars are stretched, the state had relatively poor performance for its investments in support for public health care. www.unitedhealthfoundation.org.

Similarly, the Kids Count report for 2004 placed NM 48th in the nation, largely for performance on poverty related issues: percent of families headed by single parent (NM 32%, US 27%); children in poverty (NM 32%, US 21%); children living in families where no parent has full-time, year-round employment (NM 38%, US 28%); teens age 16-19 not attending school and not working (NM 14%, US 9%); teens 16-19 who are high school drop outs (NM 14%, US 10%); teen age 15-19 death rate for accident, homicide and suicide (NM 92/100,000 and US 60/100,000); and teen age 15-19 birth rate (NM 46/1,000 and US 33/1,000). NM compared somewhat favorably to the US for low birth weight babies (NM 7.5%, US 7.4%); infant mortality (NM 6.2/1,000 live births, US 7.3/1,000 live births).

Because of a younger age structure than the nation, the state crude death rate was lower than the nation: for 2003 the rate in NM was 806.7 compared to a US rate of 845.3. Leading causes were heart disease, malignant neoplasms and unintentional injury. Leading causes among children 1-14 were unintentional injuries, congenital malformations, malignant neoplasms and intentional injuries. The risk reduction and prevention opportunities in this brief sketch are significant, with much known about evidence-based interventions. For persons born in 2003, life expectancy for NM males in 2003 was 72.6 years at birth, 1.9 years shorter than for US male; for females it was 77.4 years at birth and 2.5 years shorter than for US females.

The 2005 needs assessment provides critical information on the health of the MCH population and issues that demand attention. The ultimate selection of the state performance measures are an indication of the Title V MCH priorities:

v The number of NM counties and tribal entities that are implementing positive youth development strategies as defined by 6 criteria: evidence continues to build that demonstrates a strong association between family, school and community expectations and support and lower rates of youth risk behaviors that can have short and long term consequences.

v The percent of first newborns and mothers who receive home-visiting programs: there is a large body of evidence that shows that new parents, particularly those with socio-economic disadvantage, are better equipped with the guidance of home visitors, and that rates of injury, child abuse, illness and emergency room use, and many other outcomes improve.

v Reduce unintended pregnancy to less than 30% of births: the focus in NM is on teens for whom 75% or more of births were result of an unintended pregnancy; which is, in turn, associated with higher rates of serious health risk behaviors.

v Reduce the number of children witnessing violence: this priority relates to state priorities, and to the urgent need to reduce the use of violent solutions for everyday problems among NM parents and intimate partners. Children who witness violence have short and long term health and behavioral problems.

v Increase the proportion of women who report having all six criteria of the NM Healthy Birth Index: improved birth outcomes as well as quality of life for infants and families is strongly linked to an intended pregnancy, to not drinking/using tobacco; not being physically abused; getting early and continuous prenatal care and use of folic acid to prevent birth defects.

v Reduce the proportion of women who report being physically abused by a husband or partner during pregnancy: NM ranks highest among the 33 PRAMS states for this indicator, it is related to children witnessing violence and has significant bearing on a new mother's quality life and on the parenting a child receives; and is associated with the growing problem of post-partum depression.

v Reduce the prevalence of childhood obesity and overweight: this is a national and state priority, the focus is on youth for whom data are available. There is a real need to obtain actual BMI information on younger children to be able to develop strategies earlier than the teen years.

N.M. DEPARTMENT OF HEALTH PRIORITIES AND TITLE V MCH PROGRAM ROLES AND RESPONSIBILITIES

The DOH restructured its Strategic Plan and is priorities in January 2005 when the new Cabinet Secretary assumed her position. The Department's priorities were condensed into 9 Program Areas. The Title V Program is located in the Prevention and Disease Control Section of the Department. The six top priorities for this area of the Public Health Division are:

v immunization of children,

v prevention of teen pregnancy,

v improvement of the weight of adults and youth,

v prevention of youth suicide,

v prevention of the transmission of Hepatitis C,

v prevention and control of chronic disease.

The Title V Program's roles and responsibilities in this framework are to focus on teen pregnancy as well as improving the weight of adults and children as Department priorities for Program Area 1. For Program Area 2, the Department priorities are to improve access to medical and dental health services in agency-funded primary care centers.

The Department is also focusing on improving access to WIC, Family Planning, Families FIRST Perinatal Case Management, and Children's Medical Services. These priorities are in line with Title V

priorities and Title V is focusing on reducing disparities in program access. The Department also set a priority to increase the number of primary health care and emergency medical professionals supported or obligated per year and working in underserved areas as well as reducing the percentage of Medical and Dental provider positions vacant over 6 months in community-based health centers. The Department is also trying to increase the number of children screened for sealants by the DOH sealant program. The Department will also implement 34 new school based health centers in a priority move to improve access to health services, particularly for adolescents.

The New Mexico Title V agency conducts a comprehensive needs assessment every five years, to identify state MCH priorities, to arrange programmatic and policy activity around these priorities, and to develop state performance measures to monitor the success of the program's efforts. The assessment methodology is population-based and community focused. Data used include surveillance and reporting data, findings of evaluation studies, findings or reports from communities, needs assessments done by other entities, descriptions, and distributions of MCH related health resources, written policies, written plans and other documentation about the health of this population. Needs assessments are data-driven, but, in recognition of the politics of policy-making, program development and resource allocation in public health, the needs assessment also engages and involves community stakeholders.

The Title V Management Team accomplished a review of selected Title V MCH specific performance measures and health indicators by population group, seeking input on what factors needed to be addressed to improve overall performance on the indicators and to address known gaps, disparities or barriers or build on strengths. The team reviewed access to and use of recommended primary, preventive and specialty care. Children with special health care needs were one focus of access to specialty care. The assessment was organized around 3 MCH populations: maternal and infant health in terms of women's health in pre-conceptional, prenatal and post-partum periods and infant health; child health ages 0-14, and youth health ages 15-21. This section of the assessment included the dimensions of community-based systems and the network of partnerships. In addition there were two topics representing cross cutting concerns: fathers and families; and MCH issues regarding immigrants.

Community input took place in four public health district sites in March-April 2005: Santa Fe, Albuquerque, Roswell and Las Cruces. Each assessment exercise lasted 7 hours with 2 hours for formal presentations by FHB staff and 5 hours for soliciting input. After analyzing health indicator status, trends, gaps, and disparities, the FHB Management Team chose priorities for the Title V Program focus for the next 5 years.

The Title V Director and MCH Epidemiologist also take part in the assessment of early childhood needs throughout the year, using the Results Based Accountability (RBA) framework developed by the Fiscal Policy Institute of Santa Fe. The New Mexico Children's Cabinet has derived the outcomes and indicators to address the well being of young children and their families from birth to 5 using this method. By using RBA for the Early Childhood Action Network action planning process, the two processes will be aligned and inform each other. The two large groups involved share the same language and definitions of the framework and can align their priorities.

B. AGENCY CAPACITY

B. Agency Capacity

The New Mexico Title V program for Children and Youth with Special Health Care Needs (CYSHCN) is titled the Children's Medical Services (CMS) that collaborates with partners statewide. With limited resources, CMS has maximized its capacity to ensure an effective system of statewide services to CYSHCN.

State Program Collaboration: CMS collaborates with and receives funding from the State Laboratory Division and UNM Metabolic Consultants in the provision of Newborn Genetic Screening; works with the School for the Deaf, STEP HI Program for newborn hearing screening and follow-up; CASA, TUPAC, WIC, the ARC and UNM Hospital OB GYN Department for the Birth Defects Registry and Neural Tube Defect surveillance and prevention; and collaborates with the Health Systems Bureau for networking with the RPHCA funded centers. The NM Sickle Cell Council provides education,

screening and follow-up for sickle cell and other hemoglobinopathies. CMS partners with the WIC program in the Navajo Division of Health, Navajo Nation, in education regarding use of folic acid to prevent birth defects.
State Program Support for Communities: CMS provides medical coverage and care coordination for CYSHCN meeting the program's medical and fiscal eligibility guidelines. Also CYSHCN who are covered by Medicaid/S-CHIP and other insurance can receive clinic services in multidisciplinary CMS/UNM pediatric specialty outreach clinics, and care coordination by CMS social workers. Children under 3 with complex medical diagnoses go though the CMS Family, Infant Toddler Program (FIT) and are transitioned to CMS CYSHCN social workers at age 3, assuring ongoing medical management and coordination of care.
Coordination with Health Components of Community Based Systems: CMS's network of 60 social workers located and co-located with other health services in NM, coordinate health care for CMS CYSHCN statewide. CMS works with community councils and services with the Title XVIII Medicaid and Title XXI S-CHIP program, the largest providers of medical care, in an effort to provide and model family centered, community based, culturally competent coordinated care. The Title V CYSHCN Program integrated the purchasing specifications for CYSHCN in the Medicaid/S-CHIP RFP and subsequent contracts (FY '01) assuring a MCH definition and identification of CYSHCN, a requirement to provide care coordination (MCH definition) services and recommendation the MCOs allow specialty providers to be the primary care physician per family request. The new RFP is being written and this Title V program is assured that this special needs purchasing specification section has been continued, and now will include adults ("individuals") with special health care needs. CMS social workers provide a statewide system of oversight and care coordination for infants identified through the Newborn Genetic Screening and Newborn Hearing Screening state mandated programs, ensuring that they receive a continuum of care. After initial care for the first 3 years under the CMS/ FIT, children are transferred to CYSHCN social workers to continue care coordination. House Bill 479 was passed in the 2005 legislation that will require expanded screening for all newborns born in the state of New Mexico, from 6 diagnoses to 27. CMS is working with the State Lab, Genetic Advisory Committee and Pediatric Advisory Board to strengthen the follow-up
Coordination of Health Services with Other Services at Community Level:
Healthy Transition New Mexico is coordinated through the Healthy Transition Coordinating Council (includes representatives from DVR, Medicaid, Medicaid HMO/Salud! Programs, CMS, UNM Continuum of Care LEND Program, UNM Family and Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, and Statewide Transition Initiative Efforts & Participants) and CMS to address medical and psychosocial issues of adolescent YSHCN transition. The CMS transition team has developed a model multi-cultural, bi-lingual transition plan.
CMS social workers statewide coordinate health care for CYSHCN working with all community services impacting CYSHCN: CYFD/child protective services, Food Stamps, ISD, community organizations providing services to multicultural populations, i.e. Somos Un Pueblos Unidos, local and statewide family organizations, school systems, some faith based service organizations such as Catholic Charities, Lutheran Social Services, and community domestic violence and substance abuse coalitions.
Agencies and programs receiving Title V Maternal and Child Health Funding participate in a MCH Collaborative addressing transition, Medical Home and other MCH initiatives. Enchanted Rainbow continues the work of Double Rainbow with statewide representation, with a focus on children birth to age 5, autism, immigrant health, and infant mental health. A new Behavioral Services Collaboration began with a focus on mental health and may extend to other health and community services in terms of regionalizing resources and services in New Mexico.
B. 2 Agency Capacity: Statutes
The NM Public Health Act gives DOH authority and power to regulate the practice of midwifery. The Maternal Health Program administers this. Midwives did 30% of NM deliveries in 2002 in addition to other women's health services.
A bill was passed during the 2002 legislative session that mandates newborn hearing screening in New Mexico. The regulations were developed by DOH/CMS. This was a multiyear legislative effort that passed without additional funding provided by the legislature for this effort by CMS.
New Mexico passed a bill to cover medical diets for Genetic Inborn Errors of Metabolism effective on July 1, 2003. The act required health insurance to cover medical diets required to control Genetic

Inborn Errors of Metabolism; enacting section of the NMSA 1978.
Confidential services and minor: Parental consent is not required for, and lack thereof shall not bar children from receiving, the following services: pregnancy testing, diagnosis and treatment of sexually transmitted disease, family planning services and Human Immunodeficiency Virus testing pursuant to the Family Planning Act- Section 24-1-13, NMSA 1978, Section 24-2B-3, NMSA 1978, and 42:U.S.C.A. Section 300 et.seq., 42 C.F.R. Section 59, 42 U.S.C.A. Section 1201 et.seq., 42 U.S.C.A. Section 1296 et.seq.
The Maternal, Child, Adolescent and Family (MCAF) Health Section:
Preventive and Primary Care Services for Pregnant Women, Mothers and Infants:

The state capacity to provide these services comprises limited direct and enabling services through DOH and extensive partnerships with public and private sector entities at state, local and tribal levels. Over 54% pregnant women and infants had care paid by Medicaid and S-CHIP through its Managed Care Organizations (MCOs) and fee-for-service sites in 2003.
The Maternal Health Program oversees direct prenatal care services to about 800 women in 13 of the State's 54 local health offices (LHO) where there are no providers; and works to maintain and expand partnerships with private providers to ensure availability of prenatal care to medically indigent women where possible. The program administers the High Risk Prenatal Fund that reimburses, on a fee-for-service basis, about 20 qualified private care providers who care for about 1,000 high-risk indigent prenatal clients in a year. There is also a partnership with the University of New Mexico (UNM) Hospital to bring prenatal care to about 500 urban medical indigents and routine prenatal laboratory services for about 200 needy women through the Maternal and Infant Care Project. In 2005, the Maternal Health program consulted with the Primary Care Program because primary care clinics often provide little or no prenatal care due to lack of appropriately trained staff (few OB-Gyn specialists) or willing partners; high liability insurance rates and fear of litigation. The Maternal Health Program regulates and licenses the practice of licensed midwives and certified nurse midwives (CNMs). In 2000, over 26% of births in New Mexico were attended by CNMs, and the number of CNM services has more than doubled since 1996. Thirteen of the fifteen CNM practices in New Mexico were started in 1997 and rapid expansion continues.
The MCAF Section plans to include the Families FIRST Program into its section. This state funded perinatal and child case management program will fit very well within the context of the MCAF Section and strengthen its ties to daily direct services. Families FIRST is a perinatal case management program for pregnant women and children 0-3 years who are eligible for Medicaid designed to help them gain access to needed medical, social, educational and other services. While addressing the strengths and challenges of mothers, fathers and children, it conducts ongoing assessments of the mother and child's health, along with their emotional, social and educational needs with referral to services clients need. The program goal is to improve the quality of birth outcomes decreasing high-risk pregnancies and early identification of Children with Special Health Care Needs for treatment and intervention, as well as promoting the health of mothers and children in New Mexico.
Case management services include coordination with providers of medical as well as health related services such as nutrition services, parenting classes or education agencies, when these services have been identified as necessary to foster positive pregnancy outcomes and foster healthier infants and children. Families FIRST Program successfully negotiated contracts with the three Medicaid Managed Care Organizations (Molina, Lovelace and Presbyterian) to enable them to offer Families FIRST to their Medicaid clients. Families FIRST has a provider network with 45 sites statewide. They cover 23 out of the 33 counties in the state and consist of 22 Local Public Health Offices and 13 Private Contractors working from their own offices in their communities. Between July 1, 2003 and June 30, 2004 there were 4455 pregnant women and 4539 children receiving perinatal case management services for a total of 8994. Between July 1, 2002 and June 30, 2003, 5210 clients were served and between July 1, 2001 and June 30, 2002 a total of 5080 clients were served. This program receives no Title V funds at this time. The Program continues to work on a system of receiving referrals from Human Services Department, Income Support Division to FF at the time of Medicaid enrollment. The 2000 PRAMS data specific to FF engaged the team in data that suggested the importance of Families FIRST Services for the continuation of breastfeeding strategies and to increase resources for smoking cessation and improve awareness for risks of alcohol abuse. The program has expanded coverage from 5000 in 2002-2003 to nearly 9000 in 2004.

The Family Health Bureau's (FHB) marketing initiatives target findings from needs assessments and included: Development of a newborn genetic screening video, brochure, poster, and other marketing materials; the follow-up to "Day One" with "Day Two" booklets about toddlers' behavior and possible associated parental feelings; billboards with public health messages about prenatal care; a video about domestic violence and its impact on children; and focus groups of adolescents to determine why they do not get into prenatal care early.
In 2004 CMS implemented a pilot study on the Navajo Nation in 3 counties. Life Long Happiness a preconception education project promoting the use of folic acid, alcohol and drug avoidance, proper diet and exercise for women of childbearing age to decrease the incidence of birth defects was completed. In 2005 WIC adopted the curriculum, which will be incorporated into their clinics statewide.

An MCH Epidemiologist will be added to the staff of MCAF who will be responsible for all Title V Block Grant reporting requirements, including collection and evaluation of MCH data. The position was funded by SSDI. This position will work on special projects such as those funded by the State Systems Development Initiative (SSDI) grant, the Early Childhood Comprehensive Systems (ECCS) grant and will contribute to data needs of the programs.
The MCAF Health Section: Preventive and Primary Care Services for Children:
The Child Health Program is being revised to reflect a broader spectrum of activities in child health. Statewide objectives are to promote and establish comprehensive policies that impact children and youth, assess and maximize resource allocation, remove administrative barriers to obtaining departmental services and assistance, to track New Mexico indicators concerning child and youth well-being, and to encourage partnerships that elevate the conversations, expertise, research, and action regarding New Mexico's Children and Youth.
In 2005 the first Childhood Report Card was produced that defines indicators to measure progress on all five of the Children's Cabinet outcomes for children birth to age five; the Early Childhood Health Programs Budget, which catalogues all of the Department's investment in young children and their families and advocates for shifting funding from intervention to prevention that will save taxpayer dollars in future years. It will also produce a Short Term Policy Agenda for fiscal year 2007 and a Long Range Strategic Population Level Plan.
CMS has 12 social workers statewide who are points of entry for the Family Infant Toddler (FIT) program, the Part C early intervention program for the state. The social workers provide service coordination for children birth to three who have or are at risk for developmental delay. Because this portion of the FIT program is located within the Title V CYSHCN program, allowing for a smooth transition of care coordination for children with special needs diagnoses. The CMS program oversees the Newborn Genetic and Hearing Screening program which screens all infants for certain treatable conditions. The CMS social workers provide service coordination to children who have been identified through the screening programs.
Children's Medical Services (CMS) has administered the Healthier Kids Fund (HKF) program since 1994, providing preventive and primary care health services to low income healthy children, and healthy immigrant children, ages 3 to 19, who are not eligible for the Medicaid and S-CHIP programs. HKF is funded by the state general fund. Income eligibility is 300% of the poverty (S-CHIP is 235%). When S-CHIP was implemented in 1998 55% of the HKF clients became eligible for S-CHIP. Due to limited funding enrollment in HKF was curtailed in 1999, causing 1200 children without health coverage. Currently enrollment in HKF is a little over 1000 children down from approximately 6,000 after S-CHIP was implemented. HKF was terminated in 2004 due to budget cuts but reinstated (with no new enrollment) by the Governor due to advocacy by immigrant mothers. Requests for more funding for the program are ongoing. The CMS CYSHCN and HKF Programs have worked closely with the Health Systems Bureau which oversees the rural primary care clinics that serve as the safety net for uninsured residents of New Mexico. The HSB and the FHB coordinated with the Primary Care Association when the HKF Program was at risk. This liaison continues.
The New Mexico State Lab will provide Cystic Fibrosis testing on-site and arrange for regional testing for the newly mandated diagnoses. HB 479 was passed in the 2005 legislation that will require expanded screening for all newborns born in the state of New Mexico, expanded screening from a current 6 to 29 tests. This expansion will align NM's test panel with proposed national standards that were drawn up by the American College of Medical Genetics, who were commissioned by MCHB and accepted by the Department of Health and Human Services. The screening tests shall include at a

minimum: 3-methylcrotonyl-CoA deficiency, 3-OH 3-CH3 glutaric aciduria,argininosuccinic academia, mitochondrial acetoacetyl-CoA thiolase deficiency, biotinidase deficiency, carnitine uptake defect, citrullinemia, congenital adrenal hyperplasia, congenital hypothroidism, cystic fibrosis, galactosemia, glutaric academia type I, Hb S/beta-thalassemia, hearing deficiency, homocystinuria, isovaleric academia, long-chain L-3-OH acyl-CoA dehydrogenase deficiency, maple syrup urine disease, medium chain acyl-CoA dehdrogenase deficiency, methylmalonic academia, phenylketonuria, proponic academia, sickle cell anemia, trifunctional protein deficiency, tyrosinemia type I; and very long-chain acyl-CoA dehydrogenase deficiency. The NB genetic advisory committee is composed of experts, who initially had reservations on the expansion of newborn screening, but are willing to work together to support the screening program with other stakeholders.
The CMS program works to assure provision of family centered, community-based, culturally competent, coordinated care including care coordination services for CYSHCN, and to facilitate the development of community based systems of services for such children and their families. The NM Title V CYSHCN program is fortunate in that their provider base serves New Mexico's small population in a large state. Key players throughout the state, many of whom share the MCH approach to care for CYSHCN, represent providers and agencies.
The Title V Program works with Parents Reaching Out, EPICS and Family Voices to assure critical family involvement in decision making and training of providers and families, collaboration regarding transition of CYSHCN, cultural competence issues and ongoing efforts in the state to create a medical home climate. Work continues with these partners on the Family Infant Toddler Interagency Coordinating Council, the MCH Collaborative and the Healthy Transition New Mexico Coordinating Council. This coordinated effort increases the capacity of the Title V CYSHCN program to meet the MCH model and to increase the participation of key players in addressing MCH initiatives. The Title V Program provides 128 multidisciplinary specialty clinics statewide assuring community based specialty care and oversight. District II has received CDC funding for the second year, enabling them to provide asthma clinics. The National Center for Cultural Competence assisted districts in planning for district appropriate cultural competence activities. The districts continue this work.
Experts from families, professions, agencies and UNM participate in the Newborn Hearing Advisory Committee and the Newborn Genetic Advisory Committee thus assuring a statewide effort to provide family-centered, culturally competent, community based, coordinated screening, follow-up and care. With limited funding and increasing costs, the Title V program is now billing for care coordination (case management) for Medicaid clients receiving clinic services. The Title V program will negotiate with the Salud! MCOs to increase the breadth of funding to include more than a 2-hour billing per child.
There is much to be done to improve New Mexico's standing in the SLAITS survey, however the interest and dedication exists statewide and is dependent on additional funding to sophisticate present statewide efforts. A grant by HRSA was approved without funding due to limited resources. NM will apply for the second round of funding. Key players in all areas share excitement that there may be funding to help the state do its work. The Title V CYSHCN program prepared a model for the development of a statewide council to oversee efforts to improve care in all areas. The Title V CYSHCN Program, CMS, works closely with UNM Continuum of Care, the Lend Program, Parents Reaching Out, Family Voices, the Health Systems Bureau RPHCA funded clinics, 1000 providers statewide, the NM Pediatric Society, the Medicaid/S-CHIP Salud! Programs, Indian Health Services, Long Term Services Family Infant Toddler Program.

The Social Security Administration's (SSA) December 2003 report on Children Receiving SSI showed New Mexico had 6,628 children under age 18 receiving benefits. Average monthly payments in New Mexico are $478.28 per month. The New Mexico SSA office is not able to provide a state breakdown of SSI recipients by ethnicity or age.

A December 2004 breakdown of SSI recipients broken down by county for those under 18 is as follows:

State & County Under 18 County Under 18
Total New Mexico 6,628
Bernalillo 1,863 McKinley 533

Catron 4 Mora 24
Chaves 274 Otero 160
Cibola 104 Quay 43
Colfax 51 Rio Arriba 170
Curry 209 Roosevelt 70
DeBaca 9 San Juan 562
Dona Ana 796 San Miguel 158
Eddy 155 Sandoval 194
Grant 78 Santa Fe 251
Guadalupe 17 Sierra 32
Harding * Socorro 110
Hidalgo 19 Taos 67
Lea 186 Torrance 75
Lincoln 39 Union 12
Los Alamos 3 Valencia 269
Luna 90

SSI beneficiaries are offered care coordination services by the CMS CYSHCN program. Medicaid Salud! coverage in New Mexico is comprehensive; CMS steps in to pay for medical services for families when their monthly income exceeds SSA limits (but still falls within CMS financial eligibility guidelines). CMS Social Workers also assist SSI recipients turning 18 to apply for benefits as adults. At one time CMS continually received a monthly list from New Mexico's Disability Determination Services program (DDS) providing names of all families allowed or denied benefits. CMS would contact these families and inform them of services offered by the program, such as care coordination. For those denied benefits, information about Parents Reaching Out, a Statewide Parent-to-Parent Organization would be provided. During FY 03, a change in the local Social Security Office computer system disabled capacity to generate an SSI denial list. Social Security is still working to remedy this problem.
Maternal Health: All Local Health Offices providing prenatal care have native Spanish-speaking clinical staff to provide care or expert translation for clients. A Mexican native Nurse Practitioner and Mexican Native M.D serve three of the 10 clinics. Focus groups of Hispanic young women and of Navajo women, young, old, urban and rural, have guided prenatal care development for the state. Facilitated group prenatal care is actively promoted to improve representation and involvement of culturally relevant material to pregnancy care. Six groups have been developed for Spanish-speaking women, and one is being developed in partnership with Indian Health Service on the Navajo reservation.
Family Planning: Local health offices and contractors providing care receive training in and technical assistance to assure the services are culturally appropriate and in accordance with DOH and federal grant requirements regarding non-discrimination. A policies and a system are in place to assure that effective and client-friendly approaches to reduce language barriers is in place including translation of materials and translation at the time of services for clients. The Family Planning Program uses an audit tool on cultural competency when they do site visits to service provider locations; this check list is used to monitor performance and to teach.
Cultural Competency --The CMS CYSHCN Program has been selected for its work in cultural competence for the Georgetown National Center for Cultural Competence monograph on best practices in cultural competence.
In response to an assessment done with the NCCC in 2000, CMS has made great strides in the area of Cultural Competency. CMS staff participate on the Department of Health's Increasing Minority Participation Task Group (IMPART) Group. This group has worked on the development and implementation of an Intercultural Communication Training Module (ICC Module), presented as a series of exercises designed to build skills of intercultural communication through various means. Staff participating in this group has contributed to the development of a Library, Listserv, Speakers Bureau and the organization of Videoconferences and Research Seminars. Staff have formed or joined multi-disciplinary cultural competency committees/task forces that meet regularly to address issues of cultural competency, linguistic access and health disparities through planned trainings and cultural learning experiences. Cultural competency professional development is addressed through a

requirement on staff evaluations that has been met each year. Efforts are made to ensure at least one Spanish-speaking employee is available in each office. CMS Staff have received training in Medical Interpretation, Spanish Terminology and other Cultural Aspects of Health Care Training. Staff serve on Boards and Committees, such as Immigrant Task Force and IMPART, dealing with specific cultural issues. Districts have worked to improve outreach, access to care and timely intervention for children with special health care needs in the American Indian population by working with staff from various tribes, Pueblos, Indian Hospitals, etc. Efforts have also been made to increase outreach to the African American Community through staff leadership and attendance at various conferences/trainings designed for addressing health issues specific to this population. Information on all above-mentioned trainings/conferences is shared with CMS staff and others through membership on boards, committees, task forces, etc.

MCH Collaborative:

The Maternal and Child Health Collaborative is a focal point for addressing MCH initiatives. The collaborative addresses Medical Home, the Transition of Youth with Special Health Care needs, and the Cultural Competence and Family Involvement Initiatives. Core partners include: UNM LEND, UNM Continuum of Care, Family Voices, Parents Reaching Out, and Children's Medical Services, Parents of Behaviorally Different Children, Educating Parents of Indian Children with Special Health Care Needs (EPICS).

Children's Medical Services supports Title V directives to provide accessible, acceptable, and appropriate health care and case coordination services regardless of race, ethnicity, or culture in a family-centered, community based, culturally sensitive (competent), comprehensive, and coordinated way. Through its 60 statewide social workers CMS serves and advocates for clients who for cultural or language issues may have difficulty accessing care. The CMS statewide staff provides bilingual, community based care to CYSHCN clients served. CYSHCN with no coverage by Medicaid/S-CHIP, private insurance, or CMS CYSHCN Program are unable to receive orthopedic care unless it is related to a CMS approved diagnosis.

C. ORGANIZATIONAL STRUCTURE

C. Organizational Structure

State Government Overview: The administration of Governor Bill Richardson consists of a structure of 12 State Departments. The Department of Health is the largest department in the state government. The New Mexico Children's Cabinet was created by Executive Order and Governor Richardson appointed Lt. Governor, Diane Denish, chairperson. She indicated that early childhood issues would be her top priority. Because the goals of the MCHB Early Childhood Comprehensive Systems grant and Children's Cabinet were aligned, it was decided that Lt. Governor would convene a group of early childhood stakeholders and experts to develop a comprehensive long term Early Childhood Agenda for New Mexico's young children and their families from birth to age 5, to implement the goals of the MCHB grant and to advise the Children's Cabinet. The Cabinet Secretaries from the Department of Health, Human Services Department, Children, Youth & Families, and the Aging and Long Term Care Departments also meet once a week to discuss issues that effect their departments and to address State Health and Human Services Initiatives. These four initiatives include Statewide Comprehensive Health Plan, Behavioral Health Plan, a Long Term Care Plan for Seniors & Individuals with Disabilities and the Medicaid System Redesign.

The new Secretary of the Department of Health, Michele Lujan-Grisham is a Cabinet Secretary and reports directly to the Governor. The two Deputy Secretaries are Jessica Sutin, responsible for Programs and Donna Cook, responsible for Administrative functions. The Secretary's Office houses the Public Information Officer, Chief Medical Officer, Chief Information Officer and the Chief Privacy Officer (HIPAA and related functions), as well as the Office of General Counsel.

The NM Department of Health (DOH) is a statewide agency organized in 5 Regions (formerly 4 that incorporated Bernalillo county into District I), each of the 54 local health offices are a state agency entity.

The DOH has organized its Program Areas into 9 program areas that reflect budgetary funding sources. The nine program areas follow. Program Area 1, entitled Prevention and Health Promotion, houses the Family Health Bureau Programs, Infectious Disease Prevention and Treatment, Improving

Health Initiative, and Chronic Disease Prevention and Control. Program Area 2 includes the Public Health District Offices and Local Health Offices, the Office of Border Health Clinical Services, Rural Health Care / Primary Care Health Systems, the Office of School Health, and Dental Services.
The PHD Division Director is Kristine Suozzi, PhD, a health educator by training. The PHD Director's Office includes two Deputy Directors; one oversees two Bureaus and Regional issues, while the other over sees the FHB and another Bureau, providing guidance and support on financial, personnel and other programmatic matters. There are four Bureaus within the Public Health Division. Family Health Bureau is the largest bureau. All but two Title V Programs are located within the Family Health Bureau (FHB) of the Public Health Division (PHD), in the New Mexico Department of Health (DOH). The Adolescent Health Program and the Child Safety Program are located within other DOH divisions. The Child Safety Program has been located in the Injury Prevention and Emergency Services Bureau for several years. Recently moved to the Office of School Health, Adolescent Health Program Manager reports directly to the PHD Deputy Division Director. The Division felt Adolescent Health belonged within that Office due the Governor's initiative to better fund the Office of School Health by providing 34 new school based health centers and to involve youth in policy making for those centers.
The Family Health Bureau is located in the Colgate Building at 2040 South Pacheco, about six blocks from the main DOH building. Organizational charts for the Family Health Bureau and the Public Health Division of the Department of Health are in the Appendices. The Maternal Child Health Program serves as a section of the Family Health Bureau as does the Children with Special Health Care Needs Program. The official FHB organizational charts are on file and available on request in the State Office.
The FHB is responsible for carrying out all Title V programs. Those programs with allotments under the Title V Program are: Children's Medical Services for Children with Special Health Care Needs, the Maternal Health Program, the Child Health Program, the Child Safety Program, Adolescent Health and the MCH Epidemiology Program. Other partner programs administered within the same bureau are: the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the WIC Farmer's Market Nutrition Program, the Commodity Supplemental Food Program, the Title X Family Planning Program, the state sponsored Families FIRST Perinatal Case Management Program, and the Title V Abstinence Education Program. The Dental Program resides in the same building as the Family Health Bureau. The Dental Program continues to be in the Health Systems Bureau, with easy access to the FHB/Title V MCH Agency for consultations on oral health in mothers and children.
The administration of Governor Richardson has benefited the Title V Program due to its focus on children's issues. Other streamlining has occurred within the Department as the new Secretary replaced all exempt positions with her own assignees. A SWOT analysis was completed and results were analyzed. Fortunately, some processes like travel have improved, while others have not with the administration. Personnel processes and contracting processes are still very inefficient although great effort has been exerted to try to shorten the processes. Recently, the administration announced a new plan whereby many administrative changes will take place based upon an analysis done of DOH by a private consultant.
Maternal, Child, Adolescent and Family Program (MCAF) The Child Health Program Manager's job duties are being revised to reflect a broader spectrum of activities in child health. The MCAF Section has absorbed the Families FIRST Program into its section. This state funded perinatal and child case management program will fit very well within the context of the MCAF Section and strengthen its ties to daily direct services. An MCH Epidemiologist is currently being added to the staff of MCAF to aid in the data collection and evaluation of MCH data, position funded by SSDI, to work on Title V MCH specific data and assessment tasks. This will include assistance with the development of state plan to assess childhood obesity and underweight; coordination of comprehensive assessments; the MCH Block Grant and analysis of WIC data for selected priority topics.
The MCH Epidemiology Program in the Family Health Bureau has been modified to better serve the data and information needs of the FHB and its many partners. It has incorporated the resources that support data, surveillance and epidemiology for child health needs such as birth defects, newborn hearing screening. Analysis of the CYSHCN survey and NSCH is also performed within this group.
FHB-PHD Organizational Changes
Information Technology Consolidation:
The Governor's Executive order to consolidate all information technology (IT) operations in State Government has greatly impacted IT and program operations All IT functions and staff were

consolidated within cabinet and executive agencies and now report to the agency Chief Information Officer (CIO) of that agency. The Governor's Chief Information Officer control and manage of all IT expenses within the agency, either by the establishment of an independent IT organizational budget or by the establishment of administrative financial controls of IT expenses within existing agency budgets, subject to the approval of the Cabinet Secretary. The cabinet or executive agency CIO has approval authority over all agency IT-related spending, subject to the approval of the Cabinet Secretary. The cabinet or executive agency submits a complete inventory of agency IT hardware, software and licenses in a standardized electronic format, to the Office of the CIO by June 1rst. Telecommunication equipment and personnel were expressly exempted from this section and this Order. Exceptions are made for purchases that are critical to DOH. The full impact of this order on services and operations remains to be seen. The Help Desk, once operated by the FHB on behalf of the entire Department has now been moved out of the Colgate Building and resides in the Runnels Building. Help Desk calls have been greatly reduced as staff in local offices feel that it is not as responsive as it should be. The e-mail system changed at the end of May to using Outlook.

D. OTHER MCH CAPACITY

D. Other (MCH) Capacity
D.1 FHB Chief Section: The Family Health Bureau houses 10 separate programs, a Medical Director, the Bureau Chief, and support staff who work collaboratively as a team to use resources strategically to meet identified needs within this population depending on program focus. Bureau Chief, Jane Peacock, has served as Title V Director since December 2002. She has twenty-five years of experience in public health management. She has a M.S. in Nutrition from Pennsylvania State University. Her interests are focused in the area of systems change for women and children. Medical Director, Dr. Victor La Cerva, a pediatrician, has 25 years of experience in public health medicine with DOH. He is a renowned speaker and author in the area of violence, highlighting homicide, suicide, child & elder abuse, domestic violence and sexual assault. He serves as clinical faculty with the Department of Pediatrics at UNM Medical School. He co-created the NM Men's Wellness movement, exploring the physical, emotional, mental and spiritual needs of men. He organized silent marches on gun violence, and established the "Not Even One" Team: Not one gun death in any young person is acceptable." He was interviewed by Bill Moyers, in the 1996 PBS series on preventing violence and was asked to consult with the Littleton Community after the Columbine school shootings. He is co-creator of two award winning videos. One addresses issues of young men and the other explores the adverse impact on children of exposure to domestic violence. The rest of the Bureau administrative staff consists of a dedicated Administrator and a talented Clerk Specialist. The Bureau also supports a Systems Analyst who reports directly to the Information Technology (IT) Bureau, yet supports the IT needs of Title V staff.
D.2 Childrens' Medical Services: There are 114 staff in 32 field offices throughout the state along with 14 state office staff. All staff work on Title V CYSHCN programs. The field office staff consisting of social workers, clerks, supervisors and program managers provide direct service to clients within their communities and function within the public health structure. The state office staff consists of the Title V statewide CYSHCN program manager, the medical director, 2 nurse consultants who work with newborn screening with one nurse position receiving funding from the state lab, and a Family Infant Toddler Coordinator who is funded through a JPA with the Long Term Service Division of DOH to link the Title V program with the statewide early intervention program, a clinic coordinator, financial specialist, office administrator, a health educator and clerical staff. A position is being created for a Newborn Hearing Screening Coordinator, having just received a three-year HRSA/MCH grant award. The CMS management team includes the statewide Title V CYSHCN program manager, the medical director, the field supervisors, program managers and key state office staff. The management team meets monthly to review policy issues related to the implementation of the CMS programs. The Birth Defects Prevention and Surveillance System grant from CDC ended. A grant proposal to continue the Birth Defects Registry was approved without funding. Working within the program are at least 2 parents who have children with special health care needs, and others who were children/youth with special health care needs or had sisters or brothers with special needs. In addition, the Title V

CYSHCN program contracts with Educating Parents of Indian Children to provide support and training of parents. In this way, the program has internal and external family expertise.
The CMS CYSHCN management team participates in the planning and evaluation of the delivery of services to CYSHCN. With a Statewide Program Manager who is a social worker and 4 District Program Managers who are social workers, as well as 12 Social Work Supervisors, the 52 social workers in the CYSHCN program receive ongoing supervision and evaluation of their job performance. A FIT Coordinator is a statewide consultant/supervisor assisting district supervisors in assuring federal statute compliance and job performance evaluation.
The CMS program has begun to work in collaboration with the Family Health Bureau MCH Epidemiology program to improve it's data collection and analysis of the newborn hearing screening program and other health indicators especially as reported in the 2001 SLAITS survey. Supervisors evaluate their services in an ongoing fashion, with a computer program that assists them in monitoring caseload size.
D.3 Maternal Child Adolescent Family Health: Title V Funded Staff:
Emelda M. Martinez, RN, ASN, is Section Manager, supervisor of 3 programs, 6 State office staff.
Roberta Moore, BA, CNM, is the Maternal Health Program Manager.
Rick Vigil, Child Adolescent Health Manager, is responsible for the ECCS Grant, Home visiting contract, and program activities that focus on youth.
Vacant, new MCH Epidemiologist position, SSID funded
Vacant, Health Educator: this person would assist with segments of the ECCS grant and develop the child health component of the program.
Edna Campos, Clerk Specialist, provides office support for MCAF staff.
Rima Varela, Administrator II, performs budget operations processes for MCAF program. Salary paid from Title V funds.
Staff Paid by Medicaid JPA:
Vacant, Families FIRST Program Manager, supervises 5 state staff, oversight of 4 District Coordinators, and 38 Care Coordinators in 22 counties.
Julie Colton, Social Worker Consultant, develops needs assessments, training plans to address needs, networking to achieve improved services to clients
Vacant, Registered Nurse Consultant, Provide ongoing programmatic directions and leadership to four District Coordinators, monitor the Families FIRST Provider network,
Four Registered Nurses/ District Coordinators located in the four districts throughout the state who facilitate a referral network to avoid duplication of services and address issues identified for the perinatal case management population.
Thirty eight Care Coordinators located in 22 counties throughout the state; provide care coordination for pregnant women and children, encourage participation in the program, assist clients with Presumptive Eligibility, MOSSA, Medicaid application and the MCO process; establish community resources and referral networks.
Vacant, Management Analyst, maintains financial processes.
Jessica Marquez, Medical Secretary, maintains client databases
Lorraine De Vargas, Financial Specialist, manages claims processes
Ruth Gonzales, Clerk Specialist, provides support for Families FIRST staff.

D.4 MCH Epidemiology: Susan Nalder, EdD, MPH, CNM (inactive) is Program Manager; supervises 6 positions, 3-5 contractors and 2 fellows. She directs NM PRAMS, is lead FHB staff for the Title V MCH Block Grant assessment and reporting; oversaw NM Child Fatality Review (CFR) & NM Maternal Mortality Review (MMR) and NM Birth Defects Surveillance; position funded by Title V MCH.

Ssu Weng, MD, MPH: Medical epidemiologist, lead analyst for NM PRAMS; provides TA to fellows, NM Birth Defects; and consults to many projects. Will retire September 2005; recruitment for replacement to begin July 2005. Position funded by Title V MCH..
Dorin Sisneros, NM PRAMS Survey Operations Manager, is responsible for data collection for NM PRAMS; funded by Title V MCH Block Grant.
Eirian Coronado, MA (anthropology): NM PRAMS Coordinator-Epidemiologist. Key tasks in data to action, PRAMS implementation, coordination of NM PRAMS with CDC, NM DOH and partners; funded by CDC PRAMS Cooperative Agreement.

Philip Stultz, Clerk Specialist. Provides full-spectrum of administrative and clerical support including PRAMS tasks. Funded 25% Title V MCH and 75% PRAMS Cooperative Agreement.
MCH Epidemiologist, advanced, vacant: this position was formerly assigned to CFR and MMR and vacated in early February 2005. Lacking funding, procedures are underway to transfer CFR and MMR to the Injury Prevention Program and Injury Epidemiology Program located in Epidemiology & Response Division. This position will be retooled for advanced MCH Epidemiology, to provide critically needed data and information on infant and child health; funded by Title V MCH Block Grant.
Management analyst, research assistant: pending funding, to provide research assistant tasks.
Fellows: Dr. Tierney Murphy, MD, MPH, is a CSTE-CDC MCH Epidemiology Fellow assigned to NM March 2004-March 2006. Key projects are birth defects, newborn hearing screening. Dr. Ann Do, MD, MPH, is a CDC Preventive Medicine Resident assigned to NM July 2004-June 2005. Key projects included assistance to the Title V MCH comprehensive needs assessment.
Partial funds for salary are generated through a JPA with Medicaid for PRAMS, based on Title V MCH state general fund portion of positions working on PRAMS.
D.5 The Family Planning Program (FPP) has 14 state office positions. Lynn Mundt, MBA - Program Manager; Supervises Family Planning Program Staff, oversees the FPP in local health offices and contracting agencies, prepares and monitors budgets and agency grants. Vacant -- Staff Manager. Wanicha Coggins, MD -- Medical Director; Reviews and updates clinical protocols. Serves as liaison for clinical services with the FHB Medical Director and Clinicians Group, STD Program, Breast & Cervical Cancer Program and CPI; and provides TA in planning, evaluation and data analysis for the program. Margie Montoya BSN, CNP- Nurse Practitioner Consultant; Updates clinical protocols. Serves as liaison for clinical services with the Nurse Practitioners and Clinicians group, laboratory services, Pharmacy, and local health offices. Susan Morgan MNRN - Nurse Consultant ; Coordinates and performs clinic site reviews. Serves as liaison with the Directors of Nursing Services and Nurse Managers. Oversees the Sterilization Program, client survey, and monitors clinical contracts. James Sitrick,MHS-- Male Involvement And Community Education Coordinator; Coordinates program activities on male involvement. Oversees the FPP Advisory Committee and FPP website contract. Susan Lovett, MPH - Adolescent Pregnancy Prevention Coordinator; Coordinates program activities on adolescent pregnancy prevention. Manages educational contracts including monitoring and evaluation. Coordinates FPP newsletter. Saroj Baxter, BA - Training Manager; Coordinates training activities and produces a training plan. Updates the training resource library and monitors training contracts. Manages Title X grant update. B.J. Thomas -- Management Analyst; Creates forms and databases; collects and analyzes annual surveys. Genevieve Lujan and Monica Vigil, -- Planner; Responsible for FPP contracts, provider agreements. Ferm Najera -- Administrator; program personnel and budgetary services. Lucille Duran - Fee Collection Liaison, Program client data system services. Roland Valdez - Financial Specialist, fiscal services for program.
Sarah Vigil -- Clerk, general clerical services for program.
D.6..Abstinence Education Gloria Bonner, BA, is the program manager who administers and manages contracts for implementation and evaluation.

E. STATE AGENCY COORDINATION

Organizational Relationships among the states human service agencies:
The Families FIRST program coordinates case management services with the Managed Care Organizations (MCOs) provider network to address the needs of pregnant women and children to 3 years of age. Efforts have been made to increase Medicaid reimbursement rates and provide uniform services currently services may differ from MCO to MCO and from MCO to Medicaid fee for service.
Title V Section 510 (b(2) provides funding to enable the state of New Mexico to make available abstinence education, and, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity. The Department of Health, Family Health Bureau contracts with six community-based programs to provide curriculum-based abstinence education to students in grades 6 and under during in-school hours. Additionally, after-school and summer programming is offered to students in middle school and high school. To raise statewide awareness of abstinence education, a media campaign has been implemented. Approximately 8,000 students, parents and

community members participated in abstinence education programming for FY 2005. The Abstinence Education Program cooperates and collaborates with the Family Planning Program, PRAMS, and the Office of School Health on teen pregnancy prevention issues within the Family Health Bureau.
CMS works in close collaboration with all of the state's Human Services Agencies. The CMS staff assists clients in applying for Medicaid and S-CHIP through the Medicaid On Site Application Assistance (MOSAA) and Presumptive Eligibility applications, and coordinates with the local Income Support Division (ISD) offices to assure quality client service.
The CMS-FIT staff has begun to work closely with Children Youth and Families (CYFD) to implement the requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA) legislation where children birth to three years of age with a substantiated case of abuse and neglect must be referred to early intervention. The Healthy Transition New Mexico Coordinating Council is an interagency group including the Division of Vocational Rehab (DVR), Medicaid, and Medicaid HMO/Salud! Programs, CMS, UNM Continuum of Care, the LEND Program, UNM Family and Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, EPICS, and Family Voices.
The CMS Title V CYSHCN statewide program manager was Governor appointed to the Interagency Coordinating Council (ICC), which is the advisory body to the FIT program. The Council is made up of representatives from Medicaid, CYFD, the Public Education Department, the Public Insurance Commission, the medical society, local early intervention providers, UNM and families.
The MCH Collaborative and the Enchanted Rainbow in which CMS is a member, meet quarterly to address statewide issues related to CYSHCN in collaboration with Medicaid and the Medicaid HMO/Salud! programs and other partners. The Title V Director is a member of the Early Childhood Comprehensive Services Advisory Board.
Providing services and multidisciplinary clinics statewide, the CMS Program connects with over 900 medical providers and all community social service agencies and state agencies. The CMS FIT program receives funding from the Long Term Services Division and the Coordinator provides training for FIT staff and early intervention programs regarding provision of service coordination and federal statute compliance.
The New Mexico Department of Health was awarded a grant from the Health Resources Services Administration (HRSA) to develop an infrastructure to implement a NM Oral Health Surveillance System (OHSS). In partnership with the Health Systems Bureau and District II Santa Fe CMS program, the statewide Oral Health Surveillance System (OHSS) pilot program is providing case management to over 300 clients by a part time social worker. The OHSS collects, measures and assesses oral health conditions and disparities in women, children and families and improves access to preventative and restorative services. Collaboration continues with numerous agencies, programs, and dental offices within the community. There has been significant success in promoting oral health care with our participation in community outreach events such as local health fairs, Sealant Clinics, and the CMS Cleft Palate Clinics. People are utilizing the services of the dental case manager and are eager to learn more about proper dental care for themselves and their children. Case management has been beneficial in helping clients follow through with appointments, accessing oral health care resources (including financial), and providing important educational information about oral health care maintenance. By improving access to oral health care through case management, the expected outcome is to reduce dental caries in children and establish an effective oral health screening and referral service for children and their families. (see Part IV. E. Other Program Activities for more on oral health).
E.2 Relationship of the state with selected entities:
Federally qualified health centers and primary care association(s): At the state level, the Community Health Systems Bureau oversees the primary care program, administering grants of state money and regularly communicating with each center and association, as well as the New Mexico Primary Care Association. FHB managers are meeting on an ongoing basis with the leadership of the Health Systems Bureau to study access to prenatal care statewide and to strategize how to increase access.
University of New Mexico (UNM): DOH prenatal care clinics all refer high-risk patients to primary care or private providers, or UNM Health Sciences Center (HSC), all under agreements with the Maternal Health Program to provide appropriate high risk care. UNM HSC is also under contract to provide low-risk care to 431 medically indigent Albuquerque residents; and Maternal Health collaborates with UNM HSC to improve safety net prenatal services statewide.
Tertiary care facilities: Tertiary Care Facilities are so determined by specialty services and capacity. In

NM there are two "level III perinatal facilities" with maternal-fetal specialists and neonatal specialists, and facilities to provide specialty care: University of New Mexico Hospital and Presbyterian Hospital, both located in Albuquerque and are the providers of tertiary neonatal care. They have a joint transport system to transport women in pre-term labor from around the state.
The DOH assists in training of UNM School of Medicine students and residents in their rotations through selected DOH clinics. Both hospitals provide specialists and sub-specialists providers for the DOH Children's Medical Services (CMS) cleft palate outreach clinics throughout the state. UNMH provides pediatric specialist providers in collaboration with CMS to provide 128 pediatric specialty outreach clinics a year around the state. Clinics provided include asthma, cleft palate, neurology, metabolic, endocrine, genetics and nephrology. UNMH pediatric sub specialists in metabolism and genetics are contracted to consult with the State Laboratory and CMS on CMS's Newborn Genetic Screening Follow-up Program. UNMH provides the PALS physician hotline, which provides immediate specialty consultation to physicians in the DOH and other state agencies. Specialty Departments at UNMH and other UNMH facilities provide information, consultation and collaboration on various DOH and other state projects. CMS cares for children with complex medical problems and these children often require care at a tertiary care center or by tertiary care specialty clinics.
Training Programs and University Programs: the UNM Maternal Fetal Health Department provides training for staff at rural hospitals around the state and conducts 12 outreach clinics per month throughout the state. They provide recognition management and transport for premature labor. A toll free consultation line was established for local providers throughout the state 24 hours a day 7 days a week.
Family organizations: Children's Medical Services contracts with Educating Parents of Indian Children (EPICs) to provide support and training of parents. The CMS Program receives consultation and training from Parents Reaching Out and EPICS. In addition, working within the program are at least 2 parents who have children with special health care needs, and others who were children/youth with special health care needs or had sisters or brothers with special needs. In this way, the program has internal and external family expertise. All organizations and family members internally and externally provide consultation regarding MCH initiatives and program policy. The program has experienced difficulty in contracting with family organizations due to recent ongoing revision of the contracting process within the Division.
E.3 Coordination of the Title V MCH Program with specific MCH-related programs has a long history of leadership that promoted such work on behalf of children and families.
EPSDT/Medicaid: The FHB Chief, MCAF Program Manager and MCH Epidemiologist are members of the statewide EPSDT Steering Committee. This committee is charged to discuss methods and alternatives that would be used to improve the number and quality of EPSDT screens (well child visit); preventive health guidelines are based on recommendations from the American Academy of Pediatrics.
In May, 2005 key players from state agencies and early intervention programs, the community foundations, UNM, Secretaries from HSD, PED, CYFD and DOH, as well as national experts came together to discuss and plan for improving EPSDT participation and compliance in New Mexico. A plan is in process and will be presented to the Governor and legislature. The intention is that no child will enter kindergarten with an undetected developmental delay. Title V was a key participant.
The HSD Alphabet Soup group that consisted of leadership of Medicaid, Medicaid Salud! Programs, HMO's, DOH, and CYFD met regularly to discuss maternal and child health policy issues; FHB managers participated actively; the status of this forum is not clear at the time of this submission.
Families FIRST Perinatal Case Management This program is co-located in the FHB, funded by Medicaid through reimbursement for services and provides perinatal case management to pregnant women and children ages 0-3 years. See Section B.3, MCAF Programs.
Family Planning: The Title X Family Planning Program (FPP) is part of the FHB, and is funded in part by Title V MCH. Family planning is an integral component of the Department of Health's efforts to reduce teen pregnancy, prevent unintended pregnancies and STDs, reduce infant mortality and morbidity, and improve the health of women and men of all ages. It promotes and provides comprehensive family planning services, including clinic-based services and community education and outreach, to promote health and reproductive responsibility. The FPP has three objectives: 1) To reduce teen pregnancy among girls 15 -- 17 years to a rate of no more than 50 per 1000 by the year 2005. 2) To reduce to no more than 45% the proportion of all pregnancies that are unintended in

females 13 -- 44 by 2005. 3) To reduce the prevalence of chlamydia trachomatis among young women under the age of 25 to no more than 5% by 2005. Family planning activities are collaborative between federal, regional, state, local, and non-profit organizations. Special focus projects include the Family Planning 1115 Medicaid Waiver; adolescent pregnancy prevention; male involvement; sexual coercion; sterilization; quality assurance; clinic management; data management/fee collection; and screening for violence, alcohol, substance abuse, tobacco use (V.A.S.T.). Family planning clinical services are provided throughout the state in 53 Local Public Health Offices and 75 contracted service sites that include federally qualified health centers and primary care sites. It is home to the DOH priority team "Teen Pregnancy Prevention Action Group" with staff from the Family Planning Program, MCH Epidemiology, MCAF, the Abstinence Education Program and the Office of School Health. The group is developing plans to increase services to counties in greatest need of teen pregnancy prevention services. Through the Healthier Kids Funds the FPP has contractors statewide to provide clinical family planning, pregnancy testing, counseling and STD services to adolescents. Its initiative with the New Mexico Teen Pregnancy Coalition (NMTPC) "Challenge 2005: Reducing Teen Pregnancy in New Mexico" had results: 14 counties met the challenge of reducing teen births by 20%; seven reduced births by at least 10 % based on live birth reporting for 1998-2003.

In July 1998, the Family Planning 1115 Medicaid Waiver extended services for five years uninterrupted to all women at 185% of poverty. In July 2003, HSD/Medicaid received continuation of the waiver after input from Title X FPP and data from NM PRAMS. The 1115 Medicaid Waiver is a fee-based service, allowing basic monitoring of program outcomes despite the rapid implementation of SALUD!

WIC Program: The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program safeguards the health of pregnant, breastfeeding and postpartum women, infants and children under five years of age with a household income 185% of FPL who are at nutritional risk. The WIC Program is a preventive program, providing nutritious foods, nutrition education, referrals to health and social services, and improved access to health care in order to reduce nutrition-related health problems during critical periods of growth and development. Currently USDA has provided New Mexico funding to serve 58,775 participants per month. The WIC Program is piloting a WIC Smart card Chip on the food stamps electronic benefits card, which will allow greater flexibility for both clients and grocers. The WIC Program was the first in the nation to pilot a hybrid electronic benefits transfer card for WIC recipients using a cost effective model. The joint project with Texas is to design a prototype for the nation. While the New Mexico WIC caseload is not fully funded yet, the caseload has been granted as fast as New Mexico can hire staff and build clinics. WIC and the CMS FIT program will develop a plan to increase referrals of children with special health care needs and children with or at risk for developmental delay.

Commodity Supplemental Food: This program provides supplemental nutritious food to low-income women, infants, children and seniors. USDA donates the food. New Mexico is one of the top three states in the country for food insecurity. NM has applied for more caseload from USDA and has not been granted new caseload for several years.

Farmers Market Nutrition Programs (FMNP) This program provides fresh fruits and vegetables from farmers' markets to women, infants, and children who are nutritionally at risk and who are participating in the WIC Program. During Farmers' Market season participants receive $20 in coupons to be redeemed at local Farmers‘ Markets. From the perspective of gaps, NM has applied for senior farmers market, not asking for administrative funds, but has not received the program yet.

Nutrition and Physical Activity This is not a program but a policy initiative. The Title V Director and the Title V Child Safety Coordinator participated in activities of the Action for Healthy Kids (AFHK), a nationwide initiative dedicated to creating health-promoting schools that support sound nutrition and physical activity, and was formed in response to our nation's epidemic of overweight, sedentary, and undernourished children and adolescents. In Spring 2004 the NM AFHK Forum gathered key stakeholders to identify strategies to support New Mexico schools in collaborating with families and communities to help students build and maintain healthy, lifelong nutrition and fitness habits. This year the Legislature passed a bill to regulate Competitive Foods within schools in New Mexico. Previously, these were unregulated for nutrition content contributing to a poor environment for good nutrition.

The Title V Director worked with the SECCS network, steering committee, and Children's Cabinet Work Group to promote the concept of preschool for 4 year olds as well as the other early learning

objectives developed through this process. The internal MCH capacity for early learning initiatives is limited. To date, the Title V Child Health Manager has worked with Healthy Child Care America on their project. The Healthy Childcare America grant is now terminated. Activities started with HCCA are being followed through the Safe Kids Coalition.

Childhood Injury Prevention: The Office of Injury Prevention of the Dept. of Health takes the lead on all aspects of unintentional childhood injury. OIP and its partners target low-income families for the free distribution of child car seats, booster seats, multi-sport helmets, smoke and carbon monoxide detectors, and gun locks statewide. OIP has a contract with the National SAFE KIDS Campaign to be the sponsor for NM SAFE KIDS Coalition. For the past 15 years, the state coalition has been primarily concentrating on policy issues, assisting this year with the passing of safety equipment and licensing laws for all off road vehicles that will target 50,000 minors under 18 and a booster seat law that will target 130,000 children between the ages of 5 and 12.

Family Violence, Prevention This program is non-funded, however, the Title V Medical Director has focused on issues of family violence for the last year. He wrote two books entitled: Pathways to Peace and the 2003 report Let Peace Begin With Us: The Problem Of Violence In New Mexico, which outlines violence statistics by county, and includes resources and highlights of programs that work, continues to be disseminated and used widely throughout the state by both policy makers and non-profits. The Network Coalition against domestic and sexual violence continues to expand its influence and function well. The award winning video entitled "Stolen Childhood" has continued to be distributed widely.

The Dental Program This program is funded by state general funds and works in close collaboration with the Title V MCH Program including collaboration on the submission of a HRSA grant for dental services. The grant afforded the Department the chance to hire a Medical and Public Health Social Worker (One FTE base salary for 5 months) to serve as a case manager in the District II service area. The dental program case manager coordinated intake, assessment of oral health needs, financial eligibility determination and referral services to women, children and their families who were eligible or presumptively eligible for Medicaid or S-CHIP or who qualified for oral health treatment services on a sliding fee scale. The case manager actively participated in oral health surveillance activities with the project team. Over 200 clients have had case management; family interest in oral health is rising; a fluoride varnish program for age 0-3 began; and coordination is strong with Head Start.

CMS had a system in place to coordinate with the Social Security Administration, State Disabilities Determination Services (DDS) unit to identify families in need of appeal assistance. A monthly list was generated by DDS and sent to CMS providing names of all families allowed or denied benefits. CMS staff would contact these families and inform them of services offered by the program. Information about Parents Reaching Out (PRO), a statewide parent-to-parent organization would be provided to those denied. In 2003 a change in the local Social Security Office computer system disabled capacity to generate an SSI denial list; they are still working to remedy this problem

CMS partners with the State Division of Vocational Rehabilitation in initiatives involving Youth Transition. DVR Representatives sit on the Healthy Transition Coordinating Council; CMS promotes use of its Transition Plan to facilitate planning for youth in several areas including employment, education and training.

The Family Leadership and Support Programs (PRO, others) of the MCH Collaborative is a focal point for addressing MCH initiatives. The collaborative addresses Medical Home, the Transition of Youth with Special Health Care needs, and the Cultural Competence and Family Involvement Initiatives. Core partners include: UNM LEND, UNM Continuum of Care, Family Voices, PRO, and CMS, Parents of Behaviorally Different Children, Educating Parents of Indian Children with Special Health Care Needs (EPICS).

F. HEALTH SYSTEMS CAPACITY INDICATORS

F. Health Systems Capacity Indicators

01: The rate of children hospitalized for asthma (10,000 children less than five years of age)

Asthma hospitalization for children age 0-4 increased in the 8 year period reported from 25.4 to 33.3/10,000. The rate in all other population groups decreased. The population rate for children age 5-14 was 50% lower than ages 0-4 years in 2002.

Source: Hospital Inpatient Discharge Diagnosis (HIDD) data from NM Health Policy Commission; analysis by Glenda Hubbard, Asthma Epidemiologist, ERD/DOH

In previous years, analysis for year 2000 hospital inpatient discharge data revealed the following: Toddlers age 1 were more likely to be hospitalized than those age 3-4, and the rates for all children under age 4 were higher than for children ages 5 to 9 years. American Indian children age 0-4 had even higher rates of hospitalization for asthma than Hispanic or white children. Data for infants under one year are difficult to assess because of diagnostic difficulties in that age. More children were hospitalized who had asthma, but not as the primary diagnosis at discharge.
From 2000-2003 NM Title V obtained its data from the HIDD at the Health Policy Commission; regrettably the SAS programming for this indicator was flawed. The DOH obtained the data and did the analysis, in which we have confidence. The TVIS system does not allow correction of 2001 data, Year 2000 is a data error.

Five years of data made analysis: The rate for Black children was over twice that of other groups. Because the hospital inpatient discharge data (HIDD) of the NM Health Policy Commission does not include I.H.S. hospitals serving Navajo and Pueblo populations, data for Native American children are under-represented.
The next table shows the average annual rate of discharge for asthma, all ages, 1998-2002 and by NM counties. The top two counties, Curry and Lea, are in the southeastern corner of the state where there are an inadequate number of providers who accept payment by Medicaid and a high proportion of uninsured.

Average annual rate of asthma hospital inpatient discharges in NM In rank order by county, 1998-2002

County Percent County Percent
Curry 30.5 Cibola 8.5
Lea 26.0 Valencia 8.2
Colfax 16.8 Torrance 8.1
Roosevelt 15.6 Sierra 8.0
Luna 14.8 Sandoval 7.7
Eddy 14.4 Guadalupe 7.6
Chaves 14.3 Bernalillo 7.6
DeBaca 9.9 Otero 7.5
Hidalgo 9.9 Union 7.4
San Juan 9.9 Dona Ana 6.9
San Miguel 9.7 Santa Fe 6.5
Quay 9.6 Mora 5.5
NM 9.3 Los Alamos 4.7
Socorro 9.3 Lincoln 4.5
Grant 9.2 McKinley 3.7
Rio Arriba 9.2 Catron 2.9
Taos 8.7 Harding 0.0
Analysis by G. Hubbard, Environmental Epidemiology, NM DOH

The implications for the asthma hospital discharge data are that there continue to be places in the state where children do not have ease of access to primary care; the state's Primary Care Bureau is working to address needs in Health Professional Shortage Areas (HPSAs).

02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.
Infants under 1 year of age who received at least on periodic screen paid by Medicaid in years 2000-2003 totaled 77-81%. In 2003-04, of 18,460 infants enrolled, 74.5% had an EPSDT screen.
The EPSDT Advisory Committee of Medicaid, with membership from MCO leadership, state agencies

that are involved in assuring infant health care and community providers, meets regularly and is working to improve the ability of providers in an MCO environment to offer EPSDT services and to promote use of primary preventive care in the EPSDT category by all ages of children.

03. The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.
In 2001-02, 216 infants enrolled in SCHIP; 178 received any kind of service and 164 had at least one EPSDT screen or 75.6%. In 2002-03, of 212 SCHIP enrollees, 136 or 64% had a screen. In 2003-04, of 227 SCHIP enrollees, 164 or 72.2% had an EPSDT screen.
The EPSDT Advisory Committee of Medicaid, with membership from MCO leadership, state agencies that are involved in assuring infant health care and community providers, meets regularly and is working to improve the use of EPSDT by all ages of children.

04. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
An estimated 58% achieved an observed to expected ratio of 80% on this index. NM has been one of the nation's poorest performers for prenatal care. Capacity is not adequate to the needs for prenatal care. Primary care clinics often can provide little or no prenatal care, due to lack of appropriate or willing providers. High liability insurance rates for pregnancy care providers and the fear of litigation are significant disincentives to providers to offer pregnancy care. Geographical access is a problem in sparsely populated areas of NM, as it is for all health care. In Catron and Guadalupe Counties, prenatal care is not available. PRAMS data indicate that in 2000, the following types of women were less likely than others to receive adequate levels of prenatal care:
American Indian women (~10% of NM births): approx. 42% receiving low or no prenatal care. Teens under 19 (~16% of NM births): about 40% receiving low or no prenatal care;
Women with less than a high school education (~28% NM births): 42% receiving low or no PNC; Unmarried women (~47% of NM births): 37% receiving low or no PNC; Women whose prenatal care or delivery were paid by Medicaid: 68% did not receive adequate PNC per Kottelchuck index; Women with unintended pregnancies (~43%of NM births): Women born outside U.S. (~17% of NM births) 68% 68% did not receive adequate PNC per Kottelchuck index. PRAMS data1997 to 2000: ~ 59% of women with late or no prenatal care reported that they started care as early as they wished, suggesting many women do not value or desire early prenatal care. Focus groups done by the multi-agency Prenatal Care Task Force verify that for young Hispanic and Native American women, fear and shame are barriers to early prenatal care. The Prenatal Care Task Force this year mounted a media campaign to teach the early symptoms of pregnancy and encourage women, especially young Navajo women, to seek early testing and prenatal care. The High Risk Prenatal Care fund and local health offices serve indigent women, often arriving late in pregnancy due to lack of funds. Title V supports primary care clinics providing care to low-risk medically indigent women by paying for their routine lab tests, which otherwise are prohibitive. Cultural relevance is an issue in prenatal care for the marginalized types of women with low levels of prenatal care. Models of prenatal care in facilitated groups have demonstrated improved usage. The Family Health Bureau started eight pilot sites using such models, in public health offices, primary care sites and private offices, and is helping to start one at an HIS clinic.

05. Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State
The most recent birth+Medicaid report was 2000. NM PRAMS is the only current source of data that compares Medicaid with non-Medicaid paid mothers and infants until NM VRHS has adequate resources to link the birth file to Medicaid, and potentially the infant birth+death file to Medicaid. Estimates of low birth weight (LBW) and infant death were not produced by PRAMS; in coming years, NM PRAMS could evaluate LBW by payer of care. An estimated 32% (CI 30.3, 33.8) of all NM women had adequate prenatal care according to the Kotelchuck index (not the 80% measure used in this capacity indicator); an estimated 30.2% (CI 27.6, 32.8) of Medicaid paid mothers had adequate care. The difference was not significant. Statewide 29.3% (CI 27.5, 31.0) of mothers had later or no

prenatal care; of those on Medicaid the estimate was 34.3% (CI 31.6, 37.0), and appears to be different from all mothers; and was very much different from those with health insurance, 44.7% (CI 39.3, 50.1). Characteristics of mothers with late or no care are more important at this juncture, than those who got first trimester care.

06. The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.
Eligibility criteria in New Mexico: Infants and Children age 1-20, Medicaid = 185% FPL; Infants and Children age 0-18, SCHIP = 235% FPL. Pregnant women, Medicaid = 185% FPL.
The rate of potential eligibles to eligibles for children suggests the need for more outreach to get children in and to address issues of no coverage for children who are not eligible for Medicaid. Children age 0-20 at or below 185% of the Federal Poverty Level (FPL) are potentially eligible provided they meet all other criteria. Since 1998, NM has used an estimate of 56.3% of children developed by NM Voices for Children (the NM Kids Count organization) that was based on data from the NM Tax and Revenue Department. NM will continue to use this estimate until such time as an analysis of the 2003 NSCH for FPL can be completed. The table below shows the detail needed to assess this indicator. This indicator is somewhat difficult to work with because intercensal estimates (after 2000) are just that, the best estimate. Data for the number of eligibles and recipients is from Medicaid.

Estimates of NM Children Who Are Eligible to Apply for Medicaid, of Eligibles Who Received a Service, and of Potential Eligibles Who Received A Service, NM FY 2001-2004

Potential Number Eligible Number Recipient Number % Potential Eligible Who Enrolled % Eligibles Who Received Medicaid Paid Service % Potential Eligibles Who Received a Medicaid Paid Service
2000-01 333,589 296,894 235,136 89.0% 79.2% 70.5%
2001-02 337,370 306,330 267,063 90.8% 87.2% 79.2%
2002 to 03 338,146 311,013 265,487 92.0% 85.4% 78.5%
2003 to 04 338,489 321,074 272,894 94.9% 85.0% 80.6%

07. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year
Between 2000-2003, the proportion of children on Medicaid and who received any dental service gradually increased from 33.8% of 57,263 children to 54% of about 76,400 children age 6-9 years. In that period the number of children doubled from 20,000 to over 41,000. This progress is attributed to many factors: the DOH work with Medicaid to obtain higher rates for dental services and efforts to recruit more dentists who will accept Medicaid payment. All but 8 of the 33 counties are designated as health professional shortage areas (HPSAs) for dental care.
08. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program
Most current data show 5.2% of state SSI beneficiaries less than 16 years of age received rehabilitative services from the State Children with Special Health Care Needs Program. There appears to be a decreasing trend in this measure over the past five years, due to the level funding allocated for these services during this period. There is concern over a gap in coverage for services addressing chronic orthopedic and rehabilitation needs of uninsured children and youth in New Mexico. The merger of Carrie Tingley Hospital (which used to provide these services to children with no insurance, Medicaid, or other payor source) with the University of New Mexico (UNM) Medical Center resulted in a change in the coverage of rehabilitative services. Currently, UNM Carrie Tingley Hospital is not providing rehabilitative services to patients unless they are able to pay out of pocket. The Children's Medical Services (the state CSHCN Program) is unable to expand its program to include these medical conditions and meet this need due to its limited resources. The gap in coverage for chronic orthopedic and rehabilitative services described above results in disparate coverage for immigrant (mostly Hispanic) children, since most are unable to pay out of pocket for such services. Funding was appropriated by the Legislature to Carrie Tingley Hospital in the l980's. Until this funding is shared with the Title V CYSHCN Program, no services will be provided to immigrants who do not qualify for SSI Medicaid.

SSI and Medicaid/SCHIP are the major providers of the rehabilitative care in New Mexico. Additional programs and/or funding is needed to address this gap. The Social Security Administration's December 2003, Children Receiving SSI reports that New Mexico had 6,628 children under age 18 receiving benefits. Average monthly payments in New Mexico are $478.28 per month. The New Mexico SSA office is not able to provide a state breakdown of SSI recipients by ethnicity or age; data by county are available and is useful for monitoring needs.
A December 2004 breakdown of SSI recipients broken down by county for those under 18 is as follows
State & County <18 County <18 County <18
Total New Mexico 6,628 Guadalupe 17 Rio Arriba 170
Bernalillo 1,863 Harding * Roosevelt 70
Catron 4 Hidalgo 19 San Juan 562
Chaves 274 Lea 186 San Miguel 158
Cibola 104 Lincoln 39 Sandoval 194
Colfax 51 Los Alamos 3 Santa Fe 251
Curry 209 Luna 90 Sierra 32
DeBaca 9 McKinley 533 Socorro 110
Dona Ana 796 Mora 24 Taos 67
Eddy 155 Otero 160 Torrance 75
Grant 78 Quay 43 Union 12
Valencia 269

SSI beneficiaries are offered care coordination services by the CMS CYSHCN program. Medicaid Salud! coverage in New Mexico is comprehensive; CMS steps in to pay for medical services for families when their monthly income exceeds SSA limits (but still falls within CMS financial eligibility guidelines). CMS Social Workers also assist SSI recipients turning 18 to apply for benefits as adults. At one time CMS continually received a monthly list from New Mexico's Disability Determination Services program (DDS) providing names of all families allowed or denied benefits. CMS would contact these families and inform them of services offered by the program, such as care coordination. For those denied benefits, information about Parents Reaching Out, a Statewide Parent-to-Parent Organization would be provided. During FY 03, a change in the local Social Security Office computer system disabled capacity to generate an SSI denial list. Social Security is still working to remedy this problem.
09A. The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data
The Title V MCH Program is able to obtain data for program planning or policy from the majority of databases or surveys listed in this measure. Direct access is only a matter of having the staff to analyze the data, and satisfying data use requirements of the various database owners. Data linking with the birth or death certificate is done by the Office of Vital Records and Health Statistics (VRHS) in the Epidemiology & Response Division (ERD) of the DOH. Some linking was done by the MCH Epidemiology Program for Birth Defects and Newborn Hearing Screening in 2005 as an exceptional case because VRHS/DER lacked staff. The VRHS unit present priorities are to get the death files into a new system (from a DOS-driven system), to initiate the new birth certificate and to maintain effort with critical data management, analysis and reporting. The most current infant birth+death linkage was done for 1997-1999; this linkage is planned for 2005-06, and the MCH epidemiology program will be able to have input on the analysis plan. There are no immediate plans to link birth+Medicaid. NM PRAMS is a fine temporary substitute except that PRAMS does not have the refinement of the Medicaid claims files. To date no linkage of birth+WIC has been done; WIC files were programmed for de-duplication and download in 2003. Again, PRAMS is a temporary substitute but covers mother and infant through 9 weeks only. The newborn hearing screening has a built-in link to the birth file as four indicators are included on screening status by left and right ear, outcome (pass, fail, discharged without screen) and the type of screening equipment. Newborn genetic screening is in the loop for consideration to be linked to the birth file. The MCH Epidemiology Program (and the DOH) have ease of access to the NM Hospital Inpatient Discharge Diagnosis (HIDD) data of the NM Health Policy Commission (HPC); there are no staff who could analyze the data; data requests can be made of the HPC although they are lacking analysts who can de-duplicate files and produce other key reports.

The HIDD does not include Native American children cared for in Indian Health Service hospitals. Birth defects surveillance was done, albeit with many data quality issues, from 1997-2002. The federal birth defects grant was approved but not funded for coming 5 years; thus, the ability of the state to do this reporting is unlikely. The state PRAMS project is fully functioning and has mechanisms for sharing data, and provides extensive special reports to data clients statewide. The NM Youth Risk Resiliency Survey (YRRS) -- equivalent to YRBS- is done every 2 years; data files are readily accessed. There are many more surveillance systems available and in use by Title V MCH: Behavioral Risk Factor Surveillance for women's health and youth in transition age 18-24 years; Office of Medical Investigator; Medicaid; WIC; and more.
09B. The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.
NM has two sources for this data: the Youth Risk Resiliency Survey done every two years and the Youth Tobacco Survey done in alternate years; the latter includes middle school children. An estimated 30.2% of NM youth smoked in 2003 compared with 21.9% nationally. Smoking did increase in the 1990s (38-39% in NM youth) and shows a decrease in the 2000s. In 2003, boys (32%) smoked more than girls (27.8%). Among middle school age children in 2002, current smokers included 5% of 6th graders, 10% of 7th graders, and17% in 8th grade. There is a big leap in smoking from middle school to high school, close to twice the rate. The Youth Tobacco Survey provides essential information for prevention efforts including exposure to second hand smoke and media effects on youth.
09C. The ability of States to determine the percent of children who are obese or overweight. NM has at least seven sources to monitor overweight or obesity and related nutritional issues in children and youth: These include the WIC Program's Pediatric Nutrition Surveillance System (PedNSS for children 0-5); the YRBS (now the Youth Risk and Resiliency Survey or YRRS) conducted in high schools and middle schools in alternate years; the NM Behavioral Risk Factor Surveillance System (BRFSS) for youth in transition age 18-24; and NM PRAMS for pregnant women, including teens and youth 18-24. YRBS High School. In 2001, YRRS data was unavailable in 18 counties. In 2003, all counties submitted YRRS data on the percent of High School students who are overweight. While YRRS data is getting better each year it is done, it remains "reported" data. Actual body mass indexes are needed on all students to measure the true status of weight among high school students. At the program level, the CMS social workers screen all CYSHCN clients and the WIC Program screens all infants, children, and teens for weight issues. These screens are then reviewed by nutritionists who make referrals as appropriate. School nurses are starting to measure Body Mass Indexes in schools; however, this is not consistent throughout the state. Finally, the Department of Health is using the screening and referral of children ages 3-5 who are on the WIC Program, whose BMI-for -age is above the 95th percentile to providers of more intensive counseling, as a measure of performance. This is reported quarterly to the Legislature. To date, there are no methods to collect BMI Completion Rates at Well Child Care Visits Ages 2-28 years. Nor is there yet a methodology by which to measure the percentage of 5th, 7th, and 9th graders in New Mexico who fail to pass the minimum fitness standards.

Additional capacity issue:
The state monitors chlamydia infection in teens 15-19 and women 20-44. STDs are a serious problem that may result in infertility, and the event of a pregnancy, serious compromise for the developing fetus. Chlamydia rates are increasing, due largely to a new test. The state programs do not have adequate funds to treat cases.

The New Mexico Scientific Lab (SLD) was initially testing for Chlamydia trachomatis and Neisseria gonorroheae from swab specimens using the GenProbe Pace 2C from 1997 through the beginning of 2004.
The Aptima amplified DNA system had the advantages of providing a more lenient specimen holding time (30 days compared to 5 days for the old Pace 2C) and more lenient on temperature as Aptima system permitted specimens to be held for over a month at room temperature (compared to Pace 2C which required refrigeration).
Sensitivity for Chlamydia Detection of the Amplified Methods is 90-95% as compared to the Gen-Probe Pace 2's sensitivity of 65-75%. This change of the testing methodology is a major contributing

factor in the increase of chlamydia incidence in NM in 2004. personal communication, Wanicha B-Coggins, MD, Medical Director, NM Family Planning Program

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Title V Program uses a system approach that begins with a needs assessment and identification of priorities. It is expected the process will culminate in improved health outcomes for the target population. In 2005, the State agency conducted a comprehensive needs assessment to identify state MCH priorities. The State then developed state performance measures to monitor the success of their efforts to arrange programmatic and policy activity around these priorities. The needs assessment was population-based and community-focused. The assessment issues were organized into three categories: 1) A review of selected Title V MCH specific performance measures and health indicators by population group, seeking input on what factors needed to be addressed to improve overall performance on the indicators and to address known gaps, disparities or barriers or build on strengths, 2) A review of access to and use of recommended primary, preventive and specialty care. Children with special health care needs were one focus of access to specialty care. The assessment was organized around 3 MCH populations: maternal and infant health in terms of women's health in pre-conceptional, prenatal and post-partum periods and infant health; child health ages 0-14, and youth health ages 15-21. This section of the assessment included the dimensions of community-based systems and the network of partnerships. In addition there were 2 topics representing cross cutting concerns: fathers and families; and MCH issues regarding immigrants. The assessment was data-driven. The MCH Epidemiologist, Susan Nalder, compiled a data book using many various sources of population based data, program and selected studies or review of literature. This extensive data collection effort, resulted in the provisional NM MCH Data Book. The State reviewed the data at the State Agency level. Instead of assessing all of MCH, the State chose to assess certain aspects of MCH that were particularly troublesome for New Mexico. Using the pyramid process of prioritization and a review of the State's performance during the last 5 years, a group of State-level Program Managers and the Medical Director chose a list of 10 priorities as a framework of the assessment. To include the community and other stakeholders in the process of the development of state performance measures, the State MCH Program Managers then organized a series of town meetings in the four quadrants of the state. The assessment took place in four public health district sites in March 2005: Santa Fe, Albuquerque, Roswell and Las Cruces. Stakeholders invited included other state agencies, sister programs within the MCH state agency, county health offices, providers and facilities serving MCH populations, professional organizations, community-based and advocacy organizations, and the public.

Each facilitated assessment exercise lasted 7 hours with 2 hours for formal presentations by FHB staff and 5 hours for soliciting input. The assessment focused on ten health topics. Each topic could become a state performance measure if the assessment indicated the need. Conclusions of the assessment were used to finalize the priority needs. While several of the State performance measures were maintained, some were traded for new measures focusing on identified needs. The priority health status problems of the MCH and CYSHCN populations are attributed largely to problems associated with poverty, working families with too few resources, no universal health coverage and its related issues of access to/use of primary care, health risk behaviors associated with stresses of poverty, and a high proportion of the state's counties not having health counseling for those who have problems with substance abuse. The assessment concluded that unemployment increased and the overall poverty performance did not improve. The assessment indicated that health gaps and disparities are seen consistently among teens, parents with only a high school education or less, and single parents. These characteristics translate into greater proportions of health risk behaviors, and lower access to and use of primary preventive care or specialty care. Although the state made progress in reducing the proportion of the population that has no health insurance, critical gaps persist. There is a significant challenge in assuring access to care for the working poor and immigrant families. Male involvement was recognized as a critical factor in the health of children. While the infant mortality rate, the neonatal and post neonatal mortality rate remained lower than the national rate, disparities were also still observed. An estimated 30% of new mothers had positive behaviors with respect to the factors in the Healthy Birth Index, which indicated the need to raise prenatal health to a state priority. Home visiting and preconception health education were suggested as evidence based strategies. Some strengths identified were that more children received Medicaid services although, the risk of gaps in coverage may have increased. Medicaid has made significant

progress, increasing the number of children served by increasing the reimbursement schedule and recruiting additional dentists who would accept Medicaid. The number of women receiving dental services during pregnancy was maintained in 2004. Challenges remain first trimester prenatal care as New Mexico, lagging behind the U.S. at twice the percent for beginning, inadequate use, childhood overweight, and hunger. Twelve percent of parents surveyed indicated their children were not always safe at home and fifty percent weren't safe in their neighborhood. The number of reported domestic violence cases and the number reported with children at the scene increased from 1999-2003. Unintentional injury caused almost half the deaths in children and youth 1-24 yrs.

B. STATE PRIORITIES

Needs Assessment Generates Priorities List
The needs assessment from 2005 was reviewed and found to be consistent with policy, the evidence gathered through the needs assessment process and the direction of programs at the community level. The Title V Programs studied the data from the Title V Performance Measures, the DPH Strategic Plan, and the new NM MCH Data Book and as well as the the information obtained in the needs assessment to develop the priorities of the State for the next 5 years. The Title V staff also analyzed the capacity and resource capability of the Title V Program. Program expenditures for over the last 8 years were analyzed to note funding trends, how funds were spent within the framework of the MCH Pyramid and whether the funding was appropriately distributed to meet the needs identified in the assessment. The MCH management team brainstormed about the solutions to be implemented where possible, given current funding realities. Funding for the program had not been increased significantly for 8 years. Resources were scarce and reallocation of resources was difficult at this time, however, a map for action was determined for future funding opportunities and grants.

The three priority areas that the Family Health Bureau is focusing on are: Promoting healthy families, 2) Promoting births to healthy families and 3) working to affect a reduction intentional and unintentional injury.
In promoting healthy families, our focus is on raising healthy children by:
1. Improve access to and use of health & health related services for all MCH population groups:
Reduce barriers and disparities to accessing community-based health and health related services for women, children and youth.
Reduce medical services funding gaps for pregnant women and children in NM, such as those who are non-Medicaid eligible, children with orthopedic/rehabilitative needs, and children in need of catastrophic medical funding such as organ transplants.
2. Promote positive youth development experiences with emphasis on building personal & social assets at the family, school and community levels. The evidence base for this priority has shown that these strategies can work to reduce the proportion of youth who engage risk behaviors that may have life -- long consequences.
3. Strengthen the role of males in MCH through promotion of effective initiatives in healthy fatherhood and in reproductive health through male involvement strategies:
Expand male involvement programs in state
Expand primary prevention home visiting services to teen parents and first-time parents statewide.
4. Promoting healthy weight and physical fitness among parents and their children.
Expand parent education of healthy feeding relationships
Change the school nutrition environment, focus on competitive foods
Expand nutrition intervention for children at risk of overweight and those who are obese
5. Establish an infrastructure to support and monitor transition services for adolescents with special health care needs.
Strengthen state and local efforts across sectors that work to assure a transition with continuity of access to health care and other essential services
6. Monitor the health of immigrants across the MCH population groups
Collaborate closely with the NM Border Health Office of the DOH
Use data from the national survey of child health to understand and respond to critical needs
To increase births to healthy families, Title V will focus on these priorities
7. Improve indicators of health in the preconceptional and perinatal periods across all levels of the

Title V MCH pyramid
Expand services to support women's efforts to quit smoking and to avoid use of alcohol-related risks of pregnancy
Expand women's access to folic acid in the preconceptional and perinatal periods
Increase the proportion of women receiving adequate prenatal care.
8. Decrease unintended pregnancies and chlamydia among teens
Expand effective strategies to avert unintended pregnancy among teens including educational and clinical family planning services
Expand funding for chlamydia treatment
To affect a reduction of intentional injury (violence in families) and unintentional injury:
9. Reduce indicators of violence affecting the MCH population with focus on selected issues
Strengthen ongoing initiatives to reduce the risk of children being exposed to/witnessing violence
Monitor confirmed cases of child abuse/neglect; confirmed cases of abuse, neglect and exploitation among adults; domestic violence
Reduce the proportion of women who report physical abuse in 12 months before pregnancy and during pregnancy, through working with health care providers and targeted home visiting services to families at risk
10. Reduce rates of fatal & non-fatal unintentional injury among children and teens
Strengthen statewide programs to prevent motor vehicle crash injuries and fatalities
Strengthen safety in the home through educational initiatives, home visiting and other initiatives

These priorities are in sync with the Department's priorities of reducing teen suicide, reducing teen pregnancy, improving the weight of adults and children, improving access to medical and dental health services in agency-funded primary care centers, improving access to WIC, Family Planning, Families FIRST, and Children's Medical Services, increasing the number of primary health care and emergency medical professionals supported or obligated per year and working in underserved areas, reducing the percentage of Medical and Dental provider positions vacant over 6 months in community-based health centers, increasing the number of children screened for sealants by the DOH sealant program, and improving access for school age children by implementation of 34 new school based health centers. The statewide needs assessment exercise revealed that Regional and Local health entities of the DOH and its partners found these priorities to resonate strongly with their needs assessment efforts. In addition the assessment revealed significant work being done, across sectors, to address many of these priorities.

Priorities List vs. Title V Capacity and Resource Allocation
Increasing the access to and use of health care:
Access to health care involves Title V serving on the EPSDT Steering Committee; working to improve developmental screening of children; promoting immunizations, and case management to use scarce resources well. Data indicates that as children grow older, their well child visits decline and physicians do not do developmental screening as they should. Lack of funding does not mean that Title V cannot work to affect change. Direct Services that need expansion are chlamydia treatment, prenatal care, nutrition interventions around obesity such as counseling for children at risk of overweight or obesity. Enabling services needing focus include: access to community-based health and health related services for women, children and youth; reduction of medical services funding gaps for children in NM, Youth development, male involvement, prenatal care and parent education. Infrastructure services should focus on community based services development for populations that experience health disparities, including male involvement, and mental health. Population based services should focus on: a method to monitor and track confirmed cases of abuse of pregnant women as well as methods to reduce family violence. The annual budget is increasingly spent on provision of direct services to the MCH population. The list of priorities, while it is imperative that we provide new services such as these, the MCH budget has not increased significantly since 1997. An effort will be made to restructure the MCAF Section to focus on the priorities above for expansion of home visiting, male involvement through Family Planning, and Youth development strategies. As a new Medical Director will be hired this year, the emphasis on violence reduction will be a primary emphasis for that position. Resources for prenatal care, coordination with the WIC Program can change resources to focus on the folic acid component of prenatal care and an emphasis on reduction of smoking and

drinking among women of childbearing age. Each of the priorities above ties to a State Performance Measure for New Mexico.

New State Performance Measures will be monitored closely to see if they indicate any changes in the prevalence of these issues. If these steps are taken, the hope will be that the level of low birth weight in the State will be reduced as will perinatal, infant, neonatal, post neonatal, and child morbidity and mortality.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	20	19	20	21	18
Denominator	20	19	20	21	18
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

NM is reporting
numerator: the number of infants screened AND who were found to have a confirmed positive case AND who had appropriate follow-up.
denominator: the number of infants screened and found to have a confirmed positive case

a. Last Year's Accomplishments

a. Last Year's Accomplishments
July 1, 2003-June 30, 2004 (and to complete thru Sept 30, 2004):
FY04, Direct Health Care: Activities included monitoring contract for metabolic services at University of New Mexico. This year 6 Outreach Metabolic Clinics were held statewide. The metabolic team consists of clinical geneticists, genetic counselor and metabolic nutritionist.
FY04, Enabling Services: Provide Activities in care coordination to families identified through our program, services provided by CMS Social Workers. Training was held for CMS Social Workers regarding metabolic care. This year we monitored all birthing hospitals to ensure tracking of confirmed cases for appropriate treatment.
FY04, Population Based Services: Activities included providing training to birthing hospital and laboratory staff to ensure the quality of metabolic screening. Results on intervention are measured by reports generated by the State Lab on Unsatisfactory Screens on a quarterly basis. Training was held at 9 sites with 353 people attending.

FY04, Infrastructure Building: Activities included hiring and training a Newborn Screening Follow-up Nurse located at the State Lab, who does daily surveillance (position vacant for 1/2 year). Program follow-up policies, procedures, and algorithms have been updated.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oversee ongoing collection of newborn genetic screening samples and submission to state laboratory division				X
2. Develope Metabolic Clinic Infrastructure from 6 sites to 8 sites		X		X
3. Train Newborn providers regarding genetic screening program protocols, procedures & practices		X		X
4. Develope Strategic Plan to Improve Screening Program. Coordinate through Newborn Genetic Screening Advisory Group				X
5. Care coordination by CMS FIT social workers for families who have infants with positive genetic screen		X		
6. Development/implementation of linkage between screening and vital records to monitor coverage				X
7.				
8.				
9.				
10.				

b. Current Activities

Report of activities July 1, 2004-June 30, 2005:
NM has an estimated 26,900 to 27,000 in-state occurrence live births per year with less than 20 positives per year; all children receive appropriate follow-up and referrals. The program anticipates closing the year at or near a 100% performance in genetic screening of newborn children.
FY05, Direct Health Care: Participation in activities that include monitoring contract for metabolic services at University of New Mexico. This year 6 to 8 Outreach Metabolic Clinics will be held statewide. The metabolic team consists of a clinical geneticists, genetic counselor and metabolic nutritionist. Will continue with limited case management activities (dietary PKU levels, PKU formula ordering) with our PKU families.
FY05, Enabling Services: Activities include providing care coordination to families identified through our program, services provided by CMS Social Workers. Further training of CMS Social Workers will be on request only and for new employees.
FY05, Population Based Services: Activities include providing training to birthing hospital and laboratory staff to ensure the quality of metabolic screening. Quarterly reports will be used to target our intervention and training efforts.
FY05, Infrastructure Building: Participation in Activities that included the development of a 3-5 year plan on improving our program and integrating suggestions from our Site Assessment done by the National Newborn Screening and Genetic Resource Center. Databases linkages between Newborn Genetic Screening and Hearing Screening Program and Vital Records, electronic birth certificates will be strengthened.

c. Plan for the Coming Year

Direct Health Care: Planned activities include implementing expanded screening with all

newborns in the state of New Mexico, working closely with involved partners with the UNM, State lab, metabolic specialists, genetic advisory committee and pediatric advisory committee and CMS.
Enabling Services: Planned activities include providing in-service training to birthing hospitals and CMS social workers on expanded screening. Provide care coordination to families identified through expanded screening.
Population based services: Provide training to birthing hospitals, and lab staff to ensure the quality of expanded screening. Educate the public on expanded screening through educational brochures.
Infrastructure Building Services: Develop guidelines for genetic disorders for CMS social workers. Improve our programs follow-up policies, procedures, and algorithms in genetics. Continue efforts to develop a Statewide Genetic Plan, with all stakeholders

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				46	46
Annual Indicator			46	46	46
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	48	50	52	52	52

Notes - 2002
The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Report of activities and results, July 1, 2003-June 30, 2004 (and to complete thru Sept 30, 2004): (Previous measure, #14) The degree to which the State assures family participation in program and policy activities in the state CSHCN program:
FY04, Direct Health Care: 1) Partnering in decision-making training for parents and providers

provided through Medical Home Initiative. 2) In the State CYSHCN, ongoing family-centered approach in care coordination.
FY04, Enabling Services: 1) Family participation in MCH Collaborative, referrals to/from PRO, NM Interagency Coordinating Council, AMCHP Conference, PRO Partnership Conference, and Medical Home and Adolescent Transition Initiatives. 2) EPICS received a CMS contract to increase family involvement and provide training to parents. 3) Parents are involved as advocates in CMS multidisciplinary diagnostic clinics.
FY04, Population Based Services: AMCHP Conference, PRO Partnership Conference, and Medical Home/Adolescent Transition Initiatives; contract with EPICS, a family organization, to improve family involvement by providing staff training, parent-to-parent education, review of MCH Title V grant and consultation to program, and the support of 3 family members attendance at the AMCHP conference. Unfortunately, due to a lengthy approval process PRO did not receive a contract, but as a partner with CMS and UNM, a Medical Home Project provided transition training for providers and families regarding services that benefited CYSHCN. 1) Parents were involved as advocates in multidisciplinary diagnostic clinics. 2) Parent involvement in decision making and planning in the SDE Statewide Transition Council was critical. 3) A continued barrier that surfaced during FY03 was a change in the local Social Security office computer system disabling capacity to generate an SSI denial list that would allow us to refer clients to PRO. Although communication continued between CMS & Social Security Disability Determination Unit, reports remained unavailable. 4) A family member/parent organization representative is sitting on a MCO/Salud/Medicaid Advisory Board. 5) Parent involvement continues to be included statewide in Early Childhood and all initiatives as well as IDEA Part C. A team from New Mexico attended the Multi-State Leadership Training Meeting offered through the Champions for Progress grant at Utah State University. The team received training on all CYSHCN goals and performance measures.
The Family Planning Program within DOH will provide an all day family involvement in decision-making training for Title X providers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish contracts with family organization and/or selected family members to assure family involvement in decision making		X	X	X
2. Family organizations will provide transition training to CMS social workers and other providers on family involvement practices		X	X	X
3. Establish new or utilize existing councils to review CYSHCN survey outcomes and to develope plan for improvement				X
4. Analysis of NM specific data in national survey of CYSHCN to identify key issues to improve performance				X
5.				
6.				
7.				
8.				
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b. Current Activities

Report of activities July 1, 2004-June 30, 2005:
Although CMS was unable to contract with family organizations to provide specific services due

to a lengthy approval process, PRO and EPICS have continued on-going training with staff, providers and families.
FY05: Direct Health Care: 1) Efforts continued to expand medical home concept in New Mexico, with the discussion of the concept continuing at professional meetings and conferences. Medical home was included in discussion at the Developmental Screening Symposium 2) Continued State CYSHCN Program on-going family-centered approach in care coordination, including involvement of youth in transition planning.
FY05: Enabling Services: 1) Sustained family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, AMCHP Conference, and the Healthy Transition New Mexico Coordinating Council. 2) PKU Support Group continued more informally to provide advocacy for their families.
FY05: Population Based Services: Sustained family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, AMCHP Conference, and CMS efforts to address integration of Medical Home, as well as Healthy Transition New Mexico Council Initiatives. Contacts have been re-established between CMS and Social Security Disability Determination Unit to discuss the need for generating SSI Reports to be sent to CMS who can make referrals to PRO. It is hopeful that reports will soon be forthcoming. Family Organizations were invited to provide input into CYSHCN Program Activities during a Needs Assessment discussion held, primarily utilizing information gained in the Title V CYSHCN SLAITS Survey.
FY05: Infrastructure Building: CYSHCN Program sustained partnerships with family organizations, seeking input in all Program areas and involving them in decision making; worked with partners to identify statewide strategies to address the 6 CYSHCN performance measures; and partnered to provide input in the Medicaid redesign and the State Health Plan design resulting from a change in administration in NM. The Title V Program will contract with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision making.

c. Plan for the Coming Year

Plan for activities July 1, 2005-June 30, 2006:
2002 performance indicator shows 46% of CSHCN age 0-18 whose families' partner in decision-making at all levels and are satisfied with the services they receive. Target of 55% is set for 2007 based on reasonable estimate of impact that the CYSHCN Program, provider and agency partners can have. .
FY06: Direct Health Care: 1) Continue to expand medical home concept in New Mexico, with the discussion of the concept continuing at professional meetings and conferences. 2) Continue State CYSHCN Program on-going family-centered approach in care coordination. Special emphasis will be placed on participation of youth in their transition planning.
2006: Enabling Services: 1) Sustain family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, AMCHP Conference, and the Healthy Transition New Mexico Coordinating Council. 2) Continue PKU Support Group to provide advocacy for families.
FY06: Population Based Services: Sustain family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, AMCHP Conference, and CMS efforts to address integration of Medical Home, as well as Healthy Transition New Mexico Council Initiatives. Begin receiving reports from the Social Security Disability Determination Unit containing information on children who were denied benefits. Referrals of these children will be made to PRO.
2006: Infrastructure Building: CYSHCN Program sustains partnerships with family organizations, seeking input in all Program areas and involving them in decision making; work with partners to identify statewide strategies to address the 6 CYSHCN performance measures; and partner to provide input in the Medicaid redesign and the State Health Plan design resulting from a change in administration in NM. The Title V CYSHCN Program will contract with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision making.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				45.4	46
Annual Indicator			45.4	45.4	45.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	48	50	50	50	50

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

2004 Report of activities and results July 1, 2003-June 30, 2004 (and to complete thru Sept 30, 2004): 2004, Enabling Services: Increase to 85% the number of CYSHCN who have an identified "medical/health home". The SLAITS survey is statewide. The planned achievement for 2002 was addressing clients within the CYSHCN program only.
2004, Infrastructure Building: Champions for Progress Multi-State Meeting provided training to the CYSHCN Director, community representative and family member regarding all MCH initiatives. Newborn Hearing Screening trainings to medical providers include medical home training. Telehealth training to providers included the medical home concept. Work continued with UNM regarding the implementation of the medical home within clinics in New Mexico. Social workers from CMS continued as leaders/trainers in addressing the medical home concept. Efforts resulting from the previous Medical Home Project through UNM have resulted in more providers receiving medical home training, implementing it in their practice as possible, and increasing the state's shared knowledge of medical home. This concept is also understood and practiced within adolescent transition and cultural competence initiatives. A team from New Mexico attended the Multi-State Leadership Training Meeting offered through the Champions for Progress grant at Utah State University. The team received training on all CYSHCN goals and performance measures.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical home project will continue in 7 targeted sites - Farmington, Gallup, Albuquerque, Santa Fe, Taos, Las Cruces.	X			X
2. CMS will continue to pilot transition assessment for youth moving to an adult medical home.	X			X
3. CMS works with partners to identify statewide strategies to institute medical home.	X	X		X
4. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 2005 target of 55% is set for 2007 based on reasonable estimation of impact the CYSHCN Program coupled with provider and agency partners can have on ensuring CYSHCN ages 0-18 receive coordinated, ongoing, comprehensive care within a medical home (CSHCN Survey) 2005, Direct Health Care: CMS CYSHCN Program works with partners to identify statewide strategies to address the 6 CYSHCN performance measures. The CMS CYSHCN Program continues to pilot transition assessment for youth addressing adult medical home. 2005, Enabling Services: CYSHCN works with partners to identify statewide strategies to address the 6 CYSHCN performance measures.
2005, Infrastructure Building: CMS CYSHCN Program will continue to work with partners to identify statewide strategies to address the 6 CYSHCN performance measures. CYSHCN and partners have and are providing input in the Medicaid redesign and the State Health Plan design resulting from a change in administration in NM. CMS contacted the Medicaid program to assure that the purchasing specifications for CYSHCN that are present in the Medicaid program at this time, be carried forward in the redesign of Medicaid. In fact, the purchasing specifications have not only been continued, but have been expanded to include purchasing specifications for children AND adults with special health care needs. The state of New Mexico, under the current administration continues to plan for the ultimate goal of health coverage for all New Mexicans. Healthy Transition New Mexico Council continues to address the inclusion of the medical home concept, thus assuring a smoother transition from pediatric to adult medical care coordination. The Champions for Progress Grant was awarded and will provide an annual retreat and train the trainers meeting that will then become regional. Enchanted Rainbow -- replaced former MCH funded Double Rainbow -- continues to use Medical Home as a way to address access to care for all children and youth with special health care needs. The Title V Program will contract with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision making.

c. Plan for the Coming Year

The 2006 target of 55% is set for 2007 continues as a good estimation of impact the CYSHCN Program coupled with provider and agency partners can have on ensuring CYSHCN ages 0-18

receive coordinated, ongoing, comprehensive care within a medical home (CSHCN Survey) 2006, Direct Health Care: CMS CYSHCN Program will continue to work with partners to identify statewide strategies to address the 6 CYSHCN performance measures. The CMS CYSHCN Program continues to pilot transition assessment for youth addressing adult medical home. 2006, Infrastructure Building: CMS CYSHCN Program will continue to work with partners to identify statewide strategies to address the 6 CYSHCN performance measures. CYSHCN and partners will continue to provide input in the Medicaid redesign and the State Health Plan design resulting from a change in administration in NM. CMS leadership will meet with Salud! MCO Medicaid/SCHIP providers to address compliance with and training needed for the provision of care coordination including: medical home, transition of YSHCN, cultural competence, and community-based care. The Title V CYSHCN Program will continue to monitor and provide input to efforts being made by the current administration in its plan to ultimately provide health coverage for all New Mexicans. Healthy Transition New Mexico Council will continue address the inclusion of the medical home concept, thus assuring a smoother transition from pediatric to adult medical care coordination. The Champions for Progress Grant was awarded and will provide an annual retreat and train the trainers meeting that will then become regional. This meeting will include the medical home concept. Enchanted Rainbow -- replaced former MCH funded Double Rainbow -- continues to use Medical Home as a way to address access to care for all children and youth with special health care needs. The Title V Program will contract with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision making.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				57.4	60
Annual Indicator			57.4	57.4	57.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	62	64	66	66	66

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Achievements for 2004, Direct Health Care: Provided funding and/or services for over 4992 children and youth with special health care needs, of whom 2995 received medical care through multidisciplinary specialty clinics.
Achievement for 2004, Enabling Services: Care coordination was provided to 5683 children and youth with special health care needs. Activities and their results: CMS CYSHCN Program provided assessment of insurance options for clients, and PE-MOSAA's if the children or youth were eligible. In terms of statewide target, some children and youth with special health care needs who have Medicaid lost insurance temporarily because of semi-annual renewal difficulties.
Achievement for 2004, Infrastructure Building: The Secretary of DOH approved the closing of HKF in order to address the need for these changes within the CYSHCN program: increase in the reimbursement to CYSHCN providers through the placement of children with cancer, cardiac and renal conditions and other critical conditions on the New Mexico Medical Insurance Pool (NMMIP). The legislature provided $100,000.00 in funding for cancer treatments. While 1200 non-medicaid eligible children lost primary medical care services when HKF closed, this medical coverage was reinstated when the Governor responded to advocacy by parents of HKF covered children and youth. CMS continued to provide leadership regarding provider and pediatric specialist infrastructure issues as well as access to health care for immigrants. Planning for placement of children with high cost diagnoses on NMMIP was begun.
A team from New Mexico attended the Multi-State Leadership Training Meeting offered through the Champions for Progress grant at Utah State University. The team received training on all CYSHCN goals and performance measures.
During this legislative session, a bill was introduced to provide universal health coverage in New Mexico. Introduced by the Senate President, this bill did not pass but did receive attention in the press.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CMS works with partners to identify statewide strategies to address access to health insurance.				X
2. Work with state agencies and legislative committees to improve access.				X
3. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance.				X
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities

2005 Activities July 1, 2004-June 30, 2005:
The 2005 target of 70% is set for 2007 based on reasonable estimation of impact the CYSHCN Program coupled with other providers and agency partners can have.
2005, Infrastructure Building: CMS CYSHCN Program worked with partners to identify statewide strategies to address the 6 CYSHCN performance measures. CYSHCN and partners have and are providing input into the comprehensive State Health Plan design. CMS continues to modify the impact of Medicaid changes in benefits.
The CMS CYSHCN Program placed 18 children with high cost diagnoses on NMMIP. This program continues to place children with cancer, cardiac and renal conditions and other critical conditions on the New Mexico Medical Insurance Pool (NMMIP).
During this legislative session, a bill was once again introduced to provide universal health coverage in New Mexico.
Center for Medicare and Medicaid Services (CMS) federal funding has been allocated to New Mexico to provide reimbursement to hospitals and providers for emergent medical care for immigrants.

c. Plan for the Coming Year

2006 Direct Health Care Provided funding and/or services for over approximately 5000 children and youth with special health care needs, of whom approximately 3000 will receive medical care through multidisciplinary specialty clinics.

Plan for 2006, Enabling Services: Care coordination will be provided to approximately 6200 children and youth with special health care needs and school-age children who are not Medicaid/SCHIP eligible. Activities and their results: CMS CYSHCN Program will provide assessment of insurance options for clients, and PE-MOSAA's to determine if the children or youth are eligible. Social workers will work with families to assure that children and youth with special health care needs within CYSHCN do not temporarily lose Medicaid benefits due to.

2006 Population Based Services
2006 Infrastructure Building
This program will continue to place children with cancer, cardiac and renal conditions and other critical conditions on the New Mexico Medical Insurance Pool (NMMIP).
Center for Medicare and Medicaid Services (CMS) federal funding has been allocated to New Mexico to provide reimbursement to hospitals and providers for emergent medical care for immigrants
The CMS program will be represented on the Advisory Board for the Family-to-Family Health Information Center at Parents Reaching Out. The purpose of the program will be to educate families about the health care system and how to access services.
CYSHCN and partners will continue to provide input into the comprehensive State Health Plan design including initiatives as determined by the Children's Cabinet.
CMS will continue to provide leadership regarding provider and pediatric specialist infrastructure issues as well as access to health care for immigrants.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				66.5	68
Annual Indicator			66.5	66.5	66.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69	70	72	72	72

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

2004 Report of activities and results July 1, 2003-June 30, 2004 (and to complete thru Sept 30, 2004):
2004, Direct Health Care: Increase to 100% the number of CSHCN identified as eligible for Title V Program and are participants in needed areas of service: CMS eligible receiving nutrition services was 100 %. Nutrition screenings and referrals were provided for 5683 of CYSHCN by 4 nutritionists statewide. CMS sponsored 115 specialty clinics statewide. The clinics included: cleft lip and palette, pulmonary, neurology, dysmorphology and served ~3070 clients. The clinics provide community based care for 2995 children and youth. Providers were flown in to areas that are geographically difficult to serve.
2004, Enabling Services: Increase to 100% the number of CYSHCN who have access to a list of services, and other information about the program through referrals, linkages with other Programs/Organizations and through the use of the internal DOH Resource Directory. CMS eligible children receiving care coordination was 100% of 5683. CMS CYSHCN staff includes 52 social workers 19 clerks and 16 state office staff serving 5683 children and youth. Part C (FIT) staff includes 12 social workers and 6 clerks serving 768 children birth to three. FIT and CYSHCN social workers are involved in on-going community coordination efforts with providers, managed care organizations and early intervention programs as well as clinics and individual providers. CMS continued its work with MCOS and community agencies to increase the level of awareness and need for coordinated care in New Mexico.
While CMS met the following activities regarding the closure of HKF: assurance that all HKF clients had access to a list of community services and other information about the program, and transition efforts were completed with HKF clients, these activities were no longer needed when the Governor reopened HKF.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CMS maintains specialty clinics statewide.	X			
2. CMS will continue to provide care coordination to all CYSHCN and their families.		X		
3. CMS will continue to provide care coordination to all CYSHCN and their families.				X
4. CMS works with Medicaids Managed Care Organizations towards achieving block authorizations for services for CYSHCN.				X
5. Analysis of NM specific data in national survey of CSHCN to identify key.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY02 performance indicator and state justification targets from 2004-FY08: Target of 75% is set for 2007 based on reasonable estimation of impact the CYSHCN Program coupled with provider and agency partners can have on addressing access to community based health care services.
2005, Direct Health Care: Increase to 100% the number of CSHCN identified as eligible for Title V Program and are participants in needed areas of service: The program maintained current areas of reimbursement (items 1-9) on checklist; nutritionists continue to working in CMS clinics; care coordination which is provided by CMS staff and available to all CYSHCN and their families continues; linkages to early intervention services have been strengthened and reporting to the Part C program through data sharing development areas has been refined; specialty clinics have been maintained statewide. CMS sponsored 120 specialty clinics statewide. The clinics included: cleft lip and palette, pulmonary, neurology, renal, metabolic, and dysmorphology and served 2995 clients.
2005, Enabling Services: Increase to 100% the number of CYSHCN who have access to a list of services, and other information about the program through referrals, linkages with other Programs/Organizations and through the use of the internal DOH Resource Directory.
FY'05 Infrastructure Building: CMS CYSHCN Program will work with partners to identify statewide strategies to address 6 CYSHCN performance measures. The Title V CYSHCN Program and partners continue providing input into the Comprehensive State Health Plan and monitoring the implementation of the Medicaid plan. CMS will monitor the compliance with the purchasing specifications for CYSHCN that is present in the Medicaid program at this time. A request to increase funding of the Title V CYSHCN program continues, as it is the sole insurer of immigrant CYSHCN
A team from New Mexico attended the Multi-State Leadership Training Meeting offered through the Champions for Progress grant at Utah State University. The team received training on all CYSHCN goals and performance measures.
The Title V Director and CYSHCN Director will attend a Border Health Summit in late '05.
The Title V Director was appointed to the Children's Cabinet and also Early Childhood Action Network. Ms. Peacock has served in an advisory capacity to the Secretaries of the Departments of Health, Human Services, Aging and Children, Youth and Families in her work with the Children's Cabinet. The State of New Mexico produced the first Children's Report Card

including reporting on measures of children's health and transition to adulthood and employment. Key state leaders from state agencies, parents, early intervention programs, medical providers/pediatricians, the Interagency Coordinating Council non-profit agencies attended a Developmental Screening Symposium to identify and address unmet EPSDT needs in New Mexico.

c. Plan for the Coming Year

2006 Direct Health Care Services: Continue care coordination which is provided by CMS staff and available to all CYSHCN and their families; strengthen linkages to early intervention services and Part C program through increase child find activities with CYFD and pediatric practices; and maintain specialty clinics statewide. CMS will sponsor 120 multi-disciplinary pediatric specialty clinics statewide. The clinics will continue to include: cleft lip and palette, pulmonary, neurology, dysmorphology genetics, renal and a new FAS clinic in Santa Fe county.

2006 Enabling Services
Increase the number of CYSHCN who have access to a list of services, and other information about the program through referrals, linkages with other Programs/Organizations and through the use of the internal DOH Resource Directory. The Resource Directory will soon be web-based to allow access Statewide through any computer.
2006 Population Based Services -- CMS CYSHCN Program and the CMS FIT Program will work with partners in efforts identified to address assurance of EPSDT screening for children and youth. These partners will work together to increase the identification and early referral to early intervention services for children with or at risk for developmental delays.

2006 Infrastructure Building
The Title V Director and CYSHCN Director will work with partners to address issues identified at the Border Health Summit in '05.
The Title V Director will continue as a designee to the Children's Cabinet, and will continue to provide representation to the Early Childhood Action Network. Ms. Peacock will continue to serve in an advisory capacity to the Secretaries of the Departments of Health, Human Services, Aging and Children, Youth and Families in her work with the Children's Cabinet. The Title V Director will continue to work with partners regarding the State of New Mexico Children's Report Card, including reporting on measures of children's health and transition to adulthood and employment. The Title V Directors and te CYSHCN and CMS FIT program will continue to work with key state leaders from state agencies, parents, early intervention programs, medical providers/pediatricians, the Interagency Coordinating Council non-profit agencies regarding EPSDT needs and plans resulting from the Developmental Screening Symposium to identify and address unmet EPSDT needs in New Mexico

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective				5.8	5.9
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6.5	6.7	6.7	6.7

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

2004, Direct Health Care: All CYSHCN Social Workers (45) provide service coordination & transition planning to youth aged 14-21. CMS Transition Team seeks input into reviews of policy on transition issues for every CMS office.
2004, Population Based Services: The multi-agency/multi-disciplinary Healthy Transition New Mexico Coordinating Council (HTNMCC) continued work to address barriers/gaps in transition services. s Tools for Transition Conference gave participants tools to use in working with youth in transition & regions developed plans for improving transition services in their own communities through collaboration. CMS Transition Team utilized a tool for transition planning addressing such topics as health, education, vocation, recreation, future goals/dreams. The Transition Plan was tailored for immigrant youth & translated into Spanish. User-friendly transition booklet for youth, available in English & Spanish, was revised, printed & made available to all Social Workers working with youth. Funded by the Developmental Disabilities Planning Council & implemented by Executive Leadership Council & the Statewide Transition Coordinating Council, the Student Leadership & Self-Directed IEP Training initiative expanded training statewide on the ChoiceMaker Self-Determination Curriculum. Students learn to plan for & direct their own IEPs & related transition planning.
2004: Infrastructure Building: Reviewed/updated policy to be used by CYSHCN Social Workers in transition planning & kept in the CMS Manual of Operating Procedures. Newsletters were issued quarterly to all CMS Staff & other interested parties featuring updates on activities, resources available, & website links. A case study involving elaborate transition issues is profiled each issue. Senate Bill 287 to fund councils at $54,000 to fund entities concerned with meeting transition needs & providing leadership & professional development training to school districts. The bill failed but the Council continued to exist without funding. From 4 pilot districts in year 1 to 36 districts, state supported schools, & juvenile corrections facilities in year 3, the implementation of the Transition Outcomes Project helped districts use procedures & tools to improve their transition planning within the IEP for 14-22 year olds. The Transition Outcomes Project trains teams to review IEP files to assess quality implementation of transition planning requirements & assist school personnel to make changes in practice as needed. The annual NMSDE-sponsored Summer Transition Institute will build upon the past 5 Institutes to support

districts local action plans.
A team from New Mexico attended the Multi-State Leadership Training Meeting offered through the Champions for Progress grant at Utah State University. The team received training on all CYSHCN goals & performance measures. The team was chosen by the Healthy Transition New Mexico Coordinating Council.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition planning services to youth age 14-21 through care coordination by 45 social workers to cover all 33 counties		X	X	X
2. Educate professionals and families, all aspects youth transition, with Healthy Transition NM Coordinating Council.		X	X	X
3. Contracts with family organizations to provide training in youth transition, statewide.		X		X
4. CMS Transition Team reviews issues, works to inform policies regarding transition- age CYSHCN.				X
5. Use NM Behavioral Risk Factor Surveillance System, data for age 18-24 to monitor transition indicators.				X
6. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance.				X
7.				
8.				
9.				
10.				

b. Current Activities

2005, Direct Health Care: CYSHCN Social Workers continue to provide service coordination & transition planning to youth aged 14-21. Staff training will be determined & developed through follow-up evaluation of transition plan.
2005, Enabling Services: HTNMCC was awarded grant funding through the Champions for Progress Center to focus on transition initiatives. Work is underway to pilot a mentoring project between a local university & high school. Mentors who participate will receive university credit & a small stipend through this grant. They will then speak at a Statewide Train-the-Trainer Retreat funded by the Champions grant, on experiences in creating mentorship programs. Through technical assistance from HRSA CMS is partnering with a local documentary film company to create an inspirational training video on transition. The Transition Team created surveys to evaluate the usage of the CMS Youth Transition Plan. Review will take place & updates made accordingly. Copies of the transition booklet were printed through the University of New Mexico/Continuum of Care Project & distributed to public & private agencies dealing with transition planning for youth. CMS was unable to contract with parent organizations, but continued partnerships on transition issues.
2005, Population Based Services: Due to lengthy contracting process, CMS was unable to contract with parent organizations, but partnerships remained in providing training on transition issues. New Mexico sent a 3-member team (including the State Title V Director, Council Member & community partner) to the Champions for Progress Multi-State Meeting. The meeting focused on building partnerships, strengthening action plans, community-based strategies, & measuring progress.
2005, Infrastructure Building: CMS will review & update policy for use by CYSHCN Social

Workers in transition planning with youth. Surveys were developed to solicit input from families & social workers. Review & follow-up on transition plan usage will determine policy changes. CYSHCN Program worked with partners to identify statewide strategies to address 6 CYSHCN performance measures. CYSHCN & partners provided input in the Medicaid redesign & State Health Plan design resulting from a change in administration in NM. A request to include & address issues of immigrant children & youth continued. Legislation passed m&ating "Next Step" Graduation requirements that each high school student has the opportunity to develop a Next-Step plan, & must be reasonably informed about curricular & course options, available opportunities that lead to different post-high school options, & alternative options available if the student does not finish a planned curriculum.

c. Plan for the Coming Year

2006, Direct Health Care: CYSHCN Social Workers will continued to provide service coordination & transition planning (involving youth) to youth aged 14-21. Staff training will be determined & developed through follow-up evaluation of transition plan.
2006, Enabling Services: Through the Champions for Program Center Grant funded to the HTNMCC, mentoring pilot project between a local university & high school will continue. HTNMCC will sponsor, through Champions Grant funding, a Statewide Train-the-Trainer Retreat for attendance by regional teams established. Training topics concerning transition issues will be presented along with a panel discussion of what was learned in the mentoring pilot project. The inspiration transition training video will be completed. The CMS Transition Team will create a guided discussion tool to accompany the video. The video will be distributed to CMS Staff, HTNMCC Council & other interested agencies working with YSHCN. Surveys on the usage of the CMS Transition Plan will be evaluated, & recommendations for policy changes made accordingly.
2006, Population Based Services: New Mexico will send a 3-member team (including the State Title V Director, Council Member & family partner (preferably youth) to the next Champions for Progress Multi-State Meeting. The meeting will support efforts began from last meeting, & will be uniquely tailored to address the strengths & needs identified by state teams participating.
2006, Infrastructure Building: CMS will review & update policy for use by CYSHCN Social Workers in transition planning with youth. Surveys were developed to solicit input from consumers & social workers. Review & follow-up on transition plan usage will determine policy changes. CYSHCN Program worked with partners to identify statewide strategies to address 6 CYSHCN performance measures. CYSHCN & partners provided input in the Medicaid redesign & State Health Plan design resulting from a change in administration in NM. A request to include & address issues of immigrant children & youth continued. New Mexico will enact "Next Step" Graduation requirements that each high school student has the opportunity to develop a Next-Step plan & that each student must be reasonably informed about curricular & course options, available opportunities that lead to different post-high school options, & alternative options available if the student does not finish a planned curriculum.
A team from New Mexico will attend the Multi-State Leadership Training Meeting offered through the Champions for Progress grant at Utah State University. The team will receiv training on all CYSHCN goals & performance measures. The team will be chosen by the Healthy Transition New Mexico Coordinating Council. Efforts are under way to have youth representation within the New Mexico team.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	72	72	72	72	72
Annual Indicator	66.6	64.5	64.6	71	73
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	73	7.3	74	74	75

Notes - 2002

NM data is from the SLAITS/Immunization survey of CDC

Notes - 2003

Report is for 4:3:1:3:3 from national immunization survey, coverage age 19-35 months; up to date for age. Improved performance attributed to stronger immunization program and no vaccine shortages for the reporting period.

Notes - 2004

Estimate is from the CDC National Immunization Survey done with SLAITS methodology for the state of NM.

a. Last Year's Accomplishments

2002 performance indicator and state justification for targets from 2004-FY08: The Governor has made immunization a priority. The State Immunization Program has improved this measure. Result: The State wide immunization rate is at 71% up 10% from 61%. 2004, Population Based Services: The program is in the process of Implementing an immunization registry, including recruitment and training of providers, development of electronic interfaces to facilitate provider data uplinks, and population of database with provider, Medicaid and public health (INPHORM) immunization data.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Develop statewide immunization registry (a NM Dept. of Health Initiative)				**X**
2. Build & support local and state immunization coalitions.			**X**	**X**
3. Develop an informational immunization website to promote immunization.				**X**
4. Continue to implement the Vaccines for Children program.			**X**	
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

2005 Planned Achievement Enabling Services:
2005 Planned Achievement Infrastructure Building: continue on the implementation of the Electronic Immunization Registry, which will enable providers to log on and research the immunization status of children throughout NM as opposed to a manual search. . Continue to implement the Shot Team Initiative that recruits nurses to provide agencies with additional support such as record keeping, systems issues and quality assurance.

Steve Nickell from the NM Dept. of Health (DOH) Immunization Program reported on the current status of the "Done by One" (DBO) program. The program was originally developed by the NM Medical Society's Clinical Prevention Initiative in collaboration with DOH. The program is data-driven based on gaps that were identified in the effectiveness of NM's immunization efforts. The program was announced in April, 2003 and was not introduced with a "hard sell" but recommended as one of several alternative methods of getting all children immunized. Steve provided copies of materials developed for the campaign: chart flags, refrigerator cards, immunization passports and posters. Steve explained that the fourth DtaP and the third Hepatitis B shots are the immunizations most frequently not delivered. Immunization staff have inferred from the data that families comply well with the immunization schedule and physician visits during the first year of a child's life, but by the time the child reaches 15 to18 months of age, compliance drops off significantly. These same immunizations also have a large "window of discretion" as to when providers may decide to give them. The "Done by One" campaign is intended to address this problem of children failing to get the later shots in their infant immunization series. Problems arising from children failing to get shots include an increase in pertussis cases.

A problem with the "Done by One" (DBO) schedule is that three shots are required at each 2, 4 and 6 months of age. Currently five shots are required at 12 months of age. Next year the latter will be reduced to four shots by approval of a new covalent vaccination.

Data from the program so far show that the private sector has embraced the program less enthusiastically than public clinics. However, the private providers had higher immunization rates to begin with, and did not necessarily see the need to adopt the accelerated schedule, whereas publicly funded clinics had lower rates and have seen the DBO schedule as a method of improving poor rates. Almost every practice has improved in the past two years, even those not using DBO.

In discussion it was pointed out that this require a major effort on the part of providers, even if vaccine shortages don't complicate things.

c. Plan for the Coming Year

2006 Planned Achievement Enabling Services:
2005 Planned Achievement Infrastructure Building: We are continuing the Done By One campaign, continuing the SHOT Nurse program, where contract nurses spend extended periods in practices doing reminder recall and implementing systems changes, expand immunization training in provider practices using the CHILI presentation, and implement the state immunization registry, the New Mexico Statewide Immunization Information System. More covalent vaccines will continue to be developed and to simplify the task. It was asked what the

implications are for well child exams if children finish their immunizations by twelve months and parents have reduced incentive to take their children to the physician. Steve proposed that we need to inform our providers that children are less likely to show up for well child exams after their infant shots are finished, and that they need to encourage families to continue in the second year. Diet, nutrition and anemia may be issues that can be used as "hooks". It was verified that the three Medicaid managed care organizations (MCOs) do send out reminders to families of small children. Steve proposed that that Medicaid and Dept. of Health compare data again to evaluate the effectiveness of our efforts to get children to their well child exams. Eric Wolf and Maria Varela agreed and set a date to meet with the Immunization Program staff. Paula LeSeur stated that 7% of immunizations given in NM are given in schools, mostly by school-based health centers, of which there are 34 at present.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	44	44	43	40	40
Annual Indicator	39.1	37.5	37.7	35.9	36.6
Numerator	1697	1647	1635	1556	1584
Denominator	43438	43973	43406	43291	43291
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	35	34.5	34.5	34.5

Notes - 2003

2003 provisional data for number of births to teens; the denominator is a "best guess"; the 2003 data should be considered very provisional.

a. Last Year's Accomplishments

Direct Health Care:
1) Increase services to adolescents- Result: Local health offices distributed 126,773 flyers, 8 PSAs, 4 Newspaper/Media Articles, 4 Posters, and participated in 28 Health Fairs where 950 teen clients were educated.
2) Expanded services- Result: The Family Planning Program added 24 Provider Agreement sites. 1,910 clients were served during flex hours at local health offices, 572 clients were served in mobile vans.

Enabling Services:
Target outreach efforts for adolescents- Result: 40 offices provided outreach through local high schools, mobile van unit, community colleges, alternative high schools, family related organizations and youth groups.

Population Based Services:
Provide outreach and education in local public health offices- Result: 1,458 received family planning education through educational contacts. Local health offices provided educational sessions at 320 community sites, 52 civic organizations, and 56 religious sites. 1,059 teens received family planning education.

Infrastructure Building:
1) Ensure quality assurance through training, client surveys and EMA (Standards of Care, Best Practice, and Client Centered Care)- Result: A yearly client satisfaction survey is distributed to local public health offices. Family planning provided 47 trainings with a total of 1,425 participants.
2) Develop community networks- Result: Networking with 84 local physicians, 60 health councils, 16 MCH councils, 16 religious organizations, 276 school-related contacts, and 52 detention center contacts. 1385 teens were reached through community networks.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning increase community education efforts.			X	X
2. Family Planning expand clinic hours and teen targeted services.			X	X
3. Family Planning target outreach efforts for adolescents.			X	X
4. Family Planning develop community networks.			X	X
5. Family Planning, offers clinical family planning services in local health offices, contract sites and school based health centers.	X			
6. Use of vital records, NM PRAMS, NM BRFSS and NM YRRS surveillance data to identify disparities, target program initiatives				X
7. Statewide promotion of emergency contraceptive pill (ECP)				X
8.				
9.				
10.				

b. Current Activities

Direct Health Care:
1) Increase services to the adolescents- The total number of adolescents seen at clinics for family planning services is 6422, 5794 females and 628 males.
2) Expanded services- Result: 2,366 clients were served during flex hours at local health offices, 233 clients were served in mobile vans.

Enabling Services:
Target outreach efforts for male and female adolescents- Result: 40 offices provided outreach through local high schools, mobile van unit, community colleges, alternative high schools, family related organizations and youth groups.

Population Based Services:
Provide outreach and education in local public health offices- Result: 598 received family planning education through educational contacts. Local health offices provided educational sessions at 177 community sites.

Infrastructure Building:
1) Ensure quality assurance through needs assessment, client surveys and EMA (Standards of Care, Best Practice, Client Centered Care)- Title X Family Planning conducted a state-wide needs assessment on reproductive health services among women of reproductive age in NM, continue to analyze and report NM PRAMS data for teens age 15-17 and age 18-19; with presentation of data to target groups.
A yearly client satisfaction survey is distributed to local public health offices. Family planning provided 47 trainings with a total of 1,425 participants.
2) Develop community networks- Result: Networking with 464 local physicians, 248 health councils, 70 MCH councils, 61 religious organizations, 113 school-related contacts, and 169 detention center contacts. 3891 teens were reached through community networks.

c. Plan for the Coming Year

Direct Health Care:
Increase services to the hard to reach population
Expanded services
Enabling Services:
Target outreach efforts for male and female adolescents
Population Based Services:
Provide outreach and education in local public health offices
Infrastructure Building:
1) Ensure quality assurance through needs assessment, client surveys and EMA (Standards of Care, Best Practice, Client Centered Care)- Continue to analyze and report NM PRAMS data for teens age 15-17 and age 18-19; with presentation of data to target groups.
2) Develop community networks

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40	41	42	43	44
Annual Indicator	41.3	44	48	48	48
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	48	48	50	50	50

Notes - 2002

1999, dental sealant estimate based on 1998 and 2000 report.
2002 at 48%; 2003 at 48%; there was an increase in non-profit dental sealant programs in target schools.

Notes - 2003

This is a rough estimate; no surveillance was done in this year; the dental program reported the same level of effort, hence the same estimated level of coverage. This coverage is among children enrolled in schools with a high proportion of children on the free or subsidized meal program.

Notes - 2004

This is a rough estimate; no surveillance was done in this year; the dental program reported the same level of effort, hence the same estimated level of coverage. This coverage is among children enrolled in schools with a high proportion of children on the free or subsidized meal program

NOTE; the National Survey of Children's Health found that 78.8% of children 6-9 years had dental coverage; of those with coverage, 95.6% of children 6-9 years got all routine dental care needed - the survey does not specify if sealants were part of such care. If sealants were included, this would mean that a roughly estimated 82,300 children age 6-9 got a sealant = 74.9% of all children age 6-9.

a. Last Year's Accomplishments

2004 Target: The goal for percentage of 3rd grade children
who have received dental sealants was met for 2004. The Office of Dental
Health (ODH) used state funds to provide dental sealants to the target population in schools with free and subsidized lunch programs; it serves about 75% of target
schools, a total of 120 reached by DOH staff and about 30 additional reached by
contracted services. ODH also contracted with private school based companies to increase the number of children receiving dental sealants.
2004, Direct Health Care: Activities and there results: Ensured adequate numbers and distribution of school-based providers. Private school
based companies offered preventive services to children through the use
of portable dental equipment. The ODH used general funds to increase services to the low-income families through contracts with community health care centers. A contract with the University of New Mexico (UNM) increased care for children
with early childhood caries. UNM offered hospital treatment for those children
needing extensive dental treatment. For those unable to qualify for Medicaid, the
ODH paid for the necessary services.
2004, Population Based Services: Activities and results: Ensure sealant
placement in under-served areas. Activities and results: The ODH selected schools having 50% or greater free-lunch participation
2004, Infrastructure Building: Activities and results: The ODH has helped build
infrastructure by supporting school-based companies and community health care
centers. ODH contracts with these dental providers to provide direct dental services to low-income families. The contract money resulted in an increase in preventive services, emergency dental care, and hospital dentistry

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sealant program staff (dentists, hygienists and dental assistants) target low-income schools with free & reduced lunch programs.			X	X

2. Contracts with school based health providers to provide dental sealents to target population.			X	X
3. Implement fluoride-rinse program through target-schools in communities with sub-optimal fluoride levels.				X
4. Monitor fluoride levels in community wells, free testing results for families with private wells.			X	
5. Oral Health Council (NM DOH, NM Dental Assn., UNM, Delta Dental, others) addresses oral health issues such as dental care accesses, oral health status.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2005 performance indicator for targets from 2006-FY09: The performance measure for 2005 is the number of 3rd grade children who have received protective sealants on at least one permanent molar tooth. The target was set at 50% based on the Healthy People 2000 initiative to increase to >50% the proportion of children who have received protective sealants on the occlusal surface of permanent teeth. The key factors are family income, education level, lack of access to care, low number of pediatric dentists/dentists who treat young children.
2005, Direct Health Care: Ensure children in under-served areas are receiving dental sealants. Planned Activities: The ODH will continue to use general funds to support the ongoing sealant program. ODH will also partner with private school based companies to increase the number of children receiving preventive dental treatment.
2005, Population Based Services: The ODH will target low-income children in under-served areas. Planned Activities: ODH will select schools with 50% or greater participation in the free or reduced lunch program.
2005, Infrastructure Building: Ensure adequate numbers and distribution of schoolbased sealant providers. Planned Activities: The ODH will continue its efforts to work with the NM Dental Board and NM Oral Health Council to increase access for dental care. The ODH will continue to support public-private partnerships with hopes to increase dental services to the lower income children. The ODH will use general funds to support low-income families who do not qualify for Medicaid but are in need of dental treatment.

c. Plan for the Coming Year

2006 Performance indicator for targets from 2006-FY09: The performance measure for 2005 is the number of 3rd grade children who have received protective sealants on at least one permanent molar tooth. We will continue to work towards the target that was set at 50%.
2006 Population based services: The ODH will target low-income children in under-served areas. ODH will select schools with 50% or greater participation in the free or reduced lunch program.
2006, Infrastructure Building: Ensure adequate numbers and distribution of schoolbased sealant providers. Planned Activities: The ODH will continue its efforts to work with the NM Dental Board and NM Oral Health Council to increase access for dental care. The ODH will continue to support public-private partnerships with hopes to increase dental services to the lower income children. The ODH will use general funds to support low-income families who do

not qualify for Medicaid but are in need of dental treatment.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.5	6	6	5.5	5.5
Annual Indicator	6.0	5.5	7.0	6.3	7.3
Numerator	25	25	29	26	30
Denominator	419108	454523	411531	411531	411531
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.5	5.5	5.5	5	5

Notes - 2003

Intercensal population denominators are an issue in New Mexico. The census estimates are deemed lower than the more correct estimate for the state. The more correct estimates are produced by UNM Bureau Business & Economic Research (BBER). Thus, use these rates with caution. The actual number of deaths reported to vital records is correct: past three years 29, 25, 25 deaths and a 2003 figure of 26 provisional.

a. Last Year's Accomplishments

1) The sponsorship for the New Mexico SAFE KIDS Coalition was retained at the Dept. of Health. Previously, while officially sponsored by DOH, the NMSKC was implemented and managed by a private contractor. DOH requested that the private contractor remain involved as a partner, however, the contractor declined.
It is anticipated that safety performance will improve due to the passage of a booster seat belt law in 2005, which is estimated to address the needs of 130,000 children between the ages of 5 and 12. Preparations for introduction of this legislation were made during the summer of 2004. Legislation that would have provided additional funding for more child car seats, trained technicians, and events for distribution via an additional alcohol tax failed. We will try to secure that funding mechanism again in 2006 during the budget session as we have access to less than 3,000 child car seats per year, although we estimate that we have at least 9,000 births per year to low income families. We also are unable to expand the SAFE KIDS network to other communities without additional funding.

2) The 12 SAFE KIDS organizations, in collaboration with the NM Medical Foundation, were able to purchase and distribute approximately 3,200 helmets at 16 different events. Approximately half of those helmets purchased and distributed were multi-sport to address the

safety needs of children using skateboards, scooters, and skates, as well as bicycles. DOH distributed approximately $45,000 to the four SAFE KIDS coalitions and six SAFE KIDS chapters that applied for funding to do both helmet and car seat distributions. The car seats were received primarily from other sources, including the Traffic Safety Bureau and corporate donations.

3) The NM Children, Youth and Families Dept. now has approximately 50 home safety trainers certified and 3,000 home daycare providers trained via their network of 17 annual regional early child care conferences. This curriculum was developed by the state SAFE KIDS coalition in collaboration with CYFD with additional funding from the MCHB via the Healthy Childcare grant funding. Access to the home safety curriculum has also been expanded to include the foster, adoptive and teen parents.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote implementation of the NM Child Restraing Law and the new "all positions seat belt law"			X	X
2. Develope legislative proposals for car seat funding				X
3. Expand network of SafeKids chapters with support from statewide coalition and collaboration with non-profits.				X
4. Support and evaluate the car seat certification and distribution programs.				X
5. Analysis & interpretation, non-fatal motor vehicle crash data; use in policy and program planning.				X
6. Use of fatal crash data and NM Child Fatality Review findings, fatal motor vehicle crashes in policy				X
7.				
8.				
9.				
10.				

b. Current Activities

) A booster seat law was developed the NM SAFE KIDS Coalition and partners, approved by the 2005 Legislature, and implemented on June 17th by the Motor Vehicle Division. It affects approximately 130,000 children between the ages of 5 and 12. It is hoped that safety performance will improve, as 2004 was improved for motor vehicle fatalities with drunk drivers, however, was the worst ever for non-alcohol crash deaths. Speeding and careless driving are implicated in many crashes in New Mexico. SAFE KIDS and partners also developed safety regulations for all terrain vehicles that were approved by the Legislature and will be implemented on January lst, 2006. This will affect approximately 50,000 children that currently ride ATV's.

2) The 12 SAFE KIDS organizations, in collaboration with the NM Medical Foundation, were able to purchase and distribute approximately 4,000 helmets at 16 different events. Approximately half of those helmets purchased and distributed were multi-sport to address the safety needs of children using skateboards, scooters, and skates, as well as bicycles. DOH distributed $50,400 to the four SAFE KIDS coalitions and six SAFE KIDS chapters that applied

for funding to do both helmet and car seat distributions. The car seats again were received primarily from other sources, including the Traffic Safety Bureau and corporate donations. The Bernalillo SAFE KIDS Coalition also was able to expand efforts to distribute literature for SAFE KIDS statewide.

3) The NM Children, Youth and Families Dept. added another 1,000 home daycare providers trained via their network of 17 annual regional early childcare conferences for a total of 4,000 introduced to the workshop.

c. Plan for the Coming Year

1) SAFE KIDS and partners developed safety regulations for all terrain vehicles that were approved by the 2005 Legislature and will be implemented on January lst, 2006. This will affect approximately 50,000 children that currently ride ATV's, requiring safety training and permits, helmets and goggles. There are plans to reintroduce the child helmet bill in the 2006 Legislature for the 4th time, and that would require helmets for any minor (under 18) using bicycles, skateboards, scooters or skates. The target population is approximately half a million children.
A funding mechanism to increase the statewide SAFE KIDS budget may be introduced at the 2006 Legislature as well, again via an alcohol user tax.

2) Expansion of the SAFE KIDS network from 12 to 16 chapters and coalitions will only be possible with additional approved funding from the 2006 Legislature. However, expansion of the SAFE KIDS network budget from $50,000 to approximately $60,000 may be possible via existing funds for only the one coming year. Emphasis for funding will continue to be to produce helmet distribution events and to support the production of car seat events. Under the new reorganization of National SAFE KIDS, DOH not only sponsors the NM SAFE KIDS Coalition, but also manages the entire network directly. The coalitions and chapters will no longer report their progress to the National office, but directly to the state coalition coordinator at DOH. National SAFE KIDS will also change their official name to SAFE KIDS Worldwide as they expand from their current 17 countries they are already active in.

3) The Home Safety curriculum will be introduced to at least another 1,000 home daycare providers via CYFD's RECECC conference network. This would increase the total number of those introduced to the workshop from 4,000 to 5,000 out of the approximately 8,000 home daycare providers in the state.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	75.5	76	80	80
Annual Indicator	81.2	80.1	79	83	83
Numerator					

Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83	83	83	84	84

Notes - 2002

The data source is NM PRAMS; the 2000 data are complete and final; the 2001 and 2002 data are estimates based on performance to date.

Notes - 2003

This is actually a report of breast-feeding initiation among all NM resident, NM occurrence mothers from NM PRAMS. The estimate is from 2001 data; and 2002 data will become available in late fall 2004.

Notes - 2004

Note: Estimate from NM PRAMS.

a. Last Year's Accomplishments

2004, Enabling Services:
1) Continued to provided a WIC Peer Counselor Program in Dona Ana and Valencia Counties, and one clinic in the Albuquerque metro area, and increased the mother-to-mother individual breastfeeding counseling and support to WIC breastfeeding women by expanding the program into 20 other WIC clinics statewide; resulting in a 400% expansion, reaching a total of 26 WIC clinics by the end of 2004.
2) Provided group breastfeeding support sessions and individual counseling to approximately 12,000 WIC pregnant mothers and approximately 8,000 breastfeeding mothers.
3) Supported high-risk and working mothers WIC mothers with an effective breast pump suitable to their individual needs: ~ 4,500 women received manual breast pumps; 1,000 single-user electric pumps; 1,500 multi-user electric pumps, and 150 foot-operated pedal pumps.
2004, Population Based Services:
1) Conducted outreach efforts to increase public acceptance of breastfeeding through the development and dissemination of 6,000 "Positive Images of Breastfeeding" 2004 Calendars to families through WIC and other health care providers statewide.
2) Created public awareness of breastfeeding through WIC Clinic celebrations for World Breastfeeding Week (WBW): 44 clinics sponsored a recognition ceremony or special event for clients; a press release about WBW went to all radio and TV stations statewide and 15 news articles featured breastfeeding during that week. Clients received baby "Got breast milk" tee-shirts and magnets showing breast milk storage guidelines; clinic staff received breastfeeding promotion tee-shirts, as well as "Breastfeeding and Returning to Work" for their client education sessions.
2004, Infrastructure Building:
1) Continued work to develop WIC Breastfeeding Initiation and Duration Reports.
2) Analyzed PRAMS breastfeeding data for state and community use.
3) Provided breastfeeding education and training opportunities for health care professionals statewide: WIC presented "Breastfeeding Basics" workshop in 6 locations, training approximately 110 Public Health and WIC staff, peer counselors, as well other community health care professionals; Approximately 100 WIC and Public Health Staff attended NM Breastfeeding Task Force Annual Advanced Concepts in Breastfeeding Conference.
4) Ensured WIC clinic access to adequate breastfeeding supplies and resources, listing all WIC breastfeeding materials available on a WIC intranet site.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Peer counseling & support via NM WIC and NM Breastfeeding Task Force		X	X	X
2. Provision of breast pumps via WIC, promote breast-pump access for Medicaid clients.		X	X	X
3. Media campaign and Breastfeeding Week Celebration.				X
4. Policy & program planning using WIC and NM PRAMS data Regarding breastfeeding initiation, and continuation.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2005, Direct Health Care:
1) Establish a Lactation Clinic at UNM Hospital for free counseling and support to breastfeeding mothers. Provide consultations 3 mornings a week by appointment and have referrals at the hospital set up to do frenulum clips: provide a breastfeeding class monthly; allow WIC breastfeeding peer counselors to shadow a Lactation Consultant at the hospital; provide breastfeeding training to the RN's on the mother baby unit, and to peer counselors.
2005, Enabling Services:
1) Increase mother-to-mother individual breastfeeding counseling and support to WIC pregnant/breastfeeding women through expansion of the Peer Counselor Program from 26 clinic sites to 30 clinic sites statewide.
2) Provide group breastfeeding support sessions and individual counseling to WIC pregnant/breastfeeding mothers.
3) Support high-risk and working WIC mothers with an effective/appropriate breast pump. 2005, Population Based Services:
1) Conduct outreach to increase public acceptance of breastfeeding through development and dissemination of 6,000 "Positive Images of Breastfeeding" 2005 Calendars to families through WIC and other health care providers statewide.
2) Create public awareness of breastfeeding through WIC Clinic celebrations for World Breastfeeding Week with clinic ceremonies/recognition events presenting breastfeeding mothers with a picture frame and certificates, infant "Got Breast milk" tee-shirts, clinic banners "Babies Were Born to be Breastfed", and a new musical video depicting nursing moms worldwide.
3) Develop 3 public service announcements in English and Spanish depicting the importance of fathers and the Governor, supporting breastfeeding.
2005, Infrastructure Building:
1) Complete development of WIC Breastfeeding Data Reports: Breastfeeding Initiation Report, Reasons Breastfeeding Not Initiated and Women's Expectations/Breastfeeding Initiation Report; continue development of WIC Breastfeeding Duration and Supplementation Reports.
2) Analyze PRAMS breastfeeding data for state/community use.
3) Provide breastfeeding education and training opportunities for health care professionals and breastfeeding peer counselors statewide through: an 8-hour "Breastfeeding Basics" training in 6 locations; the 2-day NM Breastfeeding Task Force Annual Advanced Concepts in

Breastfeeding Conference; and a 16-hour Peer Counselor Training Program in 4 locations.
4) Ensure WIC clinic access to adequate breastfeeding resources, with emphasis on father-involvement.
5) Develop a WIC standard curriculum for pregnant and breastfeeding client education.
6) Foster development of local community breastfeeding projects to increase the incidence of breastfeeding through granting a total of $5,000 in mini-grant funding from the New Mexico Breastfeeding Task Force (BFTF).
7) Increase the number of International Board Certified Lactation Consultants in New Mexico through providing NM BFTF scholarships to reimburse 2 approved Task Force members for IBCLC exam expenses.

c. Plan for the Coming Year

Direct Health Care:
1) Continue UNM Hospital Lactation Clinic to: provide consultations 3 mornings a week by appointment and have referrals at the hospital for frenulum clips: provide a breastfeeding class monthly; allow WIC breastfeeding peer counselors to shadow a hospital Lactation Consultant; provide breastfeeding training to mother baby unit RN's and peer counselors.
2) Develop plans to encourage hospital personnel involvement in local Breastfeeding Task Force coalitions to influence hospitals to adopt breastfeeding friendly policies.
Enabling Services:
1) Provide mother-to-mother individual breastfeeding counseling through the Peer Counselor Program to WIC clients in 30 clinic sites statewide.
2) Provide group breastfeeding support sessions and individual counseling to WIC pregnant/breastfeeding mothers.
3) Support all high-risk, working mothers WIC mothers with an effective/appropriate breast pump.
4) Provide breastfeeding education/support to WIC fathers through a new New Mexico-made video.
5) Pilot and evaluate a project to provide all WIC prenatal clients with a breastfeeding tote bag containing educational materials, supplies and incentives to successfully breastfeed their new infant.
6) Establish better coordination between WIC and La Leche League to collaborate on providing breastfeeding support groups to mothers.

Population Based Services:
1) Conduct outreach to increase public acceptance of breastfeeding by developing and disseminating 6,000 "Positive Images of Breastfeeding" 2006 Calendars to families through WIC and other health care providers statewide.
2) Create public awareness of breastfeeding through WIC Clinic events for World Breastfeeding Week.
3) Conduct a TV media campaign targeting fathers and their role in supporting breastfeeding by airing 3 PSAs produced in 2005.
Infrastructure Building:
1) Analyze WIC Breastfeeding Data Reports: Breastfeeding Initiation Report, Reasons Breastfeeding Not Initiated and Women's Expectations/Breastfeeding Initiation Report; complete development of WIC Breastfeeding Duration and Supplementation Reports.
2) Analyze PRAMS breastfeeding data for state/community use.
3) Provide training for health care professionals and breastfeeding peer counselors statewide through: an 8-hour "Breastfeeding Basics" training in 6 locations; 2-day NM Breastfeeding Task Force Annual Advanced Concepts in Breastfeeding Conference; and a 16-hour Peer Counselor Training Program for newly hired peer counselors.
4) Ensure WIC clinic access to adequate breastfeeding resources, emphasizing father-involvement.
5) Facilitate state legislation to supportive workplace breastfeeding policies.

6) Foster community breastfeeding projects by providing mini-grants from the New Mexico Breastfeeding Task Force (BFTF).
7) Increase the number of International Board Certified Lactation Consultants by providing NM BFTF scholarships to 2 BFTF members for IBCLC exam costs, and providing WIC staff resources to study for the exam.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	99	99	99	94.5	95
Annual Indicator	98.7	99.9	91.8	92.0	92.0
Numerator	26460	26751	25311	25136	25567
Denominator	26813	26791	27573	27322	27791
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95.5	95.7	96	96	96

a. Last Year's Accomplishments

2004 Report of Activities July 1, 2003- June 30, 2004 (& to complete thru Sept 30, 2004)
2004, Enabling Services: Data from hospitals, birth files, CMS/Fit social workers follow-up data is was entered into a data base. CMS began to partner with FHB Epidemiology to analyze screening data. The screening follow-up form was implemented & utilized by the CMS/Fit social workers. CMS social workers provided care coordination to ensure access to a medical home for the child & family. CMS continued to work closely with parent-to-parent organizations to ensure family satisfaction.
2004, Population Based Services: The Newborn Hearing Screening Coordinator provided training & technical assistance to all birthing hospitals on awareness & documentation of risk factors, proper referral procedures, & utilization of the electronic birth certificate. The Coordinator & State CMS staff provided intense support & technical assistance to several birthing hospitals that experienced repeated equipment failure. Partnership with the FHB Epidemiology staff began for the analysis of screening data. Training continued to be provided to all new CMS staff on proper follow-up procedures.
2004 Infrastructure Building: The Screening Coordinator continued to provide training & technical assistance to birthing hospitals & exp&ed training to medical care providers & audiologists. CMS State Office staff presented program information to the NM Department of Health/Public Health Division General Staff meeting, the New Mexico Pediatric Society, the Advances In EDHI Conference, & a poster session at the National EDHI Conference. The Newborn Hearing Screening Advisory Council was re-established to provide recommendations & guidance to the program with & focus on follow-up.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide in-service training to all birthing hospitals on quality screening procedures and data report.				X
2. Data collection on all infants referred for audiological evaluation.		X		X
3. Provide & maintain care coordination through tracking and follow-up for all infants referred.				X
4.				
5.				
6.				
7.				
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10.				

b. Current Activities

2005, performance indicator targets form FY 05 FY08: Proportion of newborns who received hearing screening & proper follow-up services.
2005, Enabling Services: Continued to follow gold standard of care of screening at within one month; identification of hearing loss by 3-4 months, & referral to early intervention services by 6 months of age. CMS provides & maintains care coordination through tracking & follow-up of all infants referred through a referral system.
2005, Population Based Services: For all infants referred from screening, identify all those with hearing loss by 3-4 months of age & begin early intervention by 6 months of age. CMS analyzes data from all sources of information regarding infants who are identified as requiring follow-up services including timeliness of contact & referrals & provide training to audiologists & PCP's on the screening program & the importance of timely intervention. Continued the partnership with FHB Epidemiology for data analysis.
2005, Infrastructure Building: Maintain the number of birthing hospitals that provide universal screening at 100%. Continue to provide in-service trainings to all birthing hospitals on quality screening procedures. Ensure all referrals receive diagnostic evaluations & medical care coordination. Explored working with a new acquired data entry program (SNAP) purchased by FHB for tracking of hospital screening & referrals. Continue with FHB Epidemiology on data analysis. Continued training & technical assistance to CMS social workers on requirements of quality care provision of the screening program. CMS State Office staff &/or Coordinator continues to present program information to health professionals & community groups. Continue the Newborn Hearing Screening Advisory Council with a focus on statewide public awareness through the use of media modalities. In 2005, the CSTE-CDC assigned MCH epidemiology fellow, Tierney Murphy, MD, MPH, used a sample of 2003 data to evaluate the program's objectives: the percent of infants screened by 30 days of age; percent who failed screening who were referred to & seen by an audiologist; & percent found to have hearing loss & referred into/participating in an early intervention program. This evaluation found need for CMS program to strengthen their system for tracking follow-up referrals; only 50% had record of followup outcome. It includes issues related to screening services & the quality of reporting by participating hospitals, CMS social workers & FIT program.

c. Plan for the Coming Year

2006 Enabling Services
Continue to follow JCIH Standard of care, screening within one month of birth, identification of hearing loss by three months & referral to early intervention services by 6 months of age. CMS will provide care coordination & maintain the infrastructure of the program.
2006 Population Based
Continue partnership with Family Health Bureau Epidemiology for data management & analysis. Implement changes & recommendations of CSTE-CDC assigned MCH epidemiology fellow, Tierney Murphy, MD, MPH who evaluated the programs objectives of screening by 1 month of age, assessment by audiologist by 3 months of age & referral to early intervention by 6 months for those children diagnosed with hearing loss. Recommendations will include issues related to screening & the quality of reporting by all program participants. Recruit & hire a full-time Newborn Hearing Screening Coordinator.
2006 Infrastructure
Maintain the number of birthing hospitals that provide universal screening at 100%. Mail out to nurse midwives referral forms with protocol to ensure that infants born at home have access to hearing screens. Continue training & technical assistance to medical providers & CMS staff. Purchase & implement a statewide data collection system to track referral & follow-up information. Continue the Newborn Hearing Screening Advisory Council with a focus on improving follow-up activities & maintaining consistent policies for screening. Coordinator will participate & chair CDC sponsored EHDI Minority Committee.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	22.5	20	20	18	18
Annual Indicator	27.7	18	18	9.6	9.6
Numerator	153355				
Denominator	553628				
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	10	10	10

Notes - 2002

The 3 year estimate of children at or below 200% poverty and had no health insurance was 14.8% (US Census, Current Population Survey). The 2000 estimate of NM children without insurance was 21% (NM Kids Count).

Notes - 2003

The most recent estimate from the Current Population Survey (CPS) for 1999-2001 was 21% of NM children were uninsured. This is the report for 2003.

Notes - 2004

Note: Data from both the Current Population Survey and the newly released National Survey of Child Health show that 9.6% of children have no insurance coverage. NM has reset its target to 10 for period 2004 thru 2009; it is not reasonable to set it lower - the state should be able to maintain ground if present priorities remain actively pursued.

a. Last Year's Accomplishments

Direct : Provided funding and/or services for 5094 children and youth with special health care needs. The Families FIRST and the CMS CYSHCN Program provides assessment of insurance options for clients, and does MOSAA/PE if the children or youth are eligible. In terms of statewide target, children and youth with special health care needs who have Medicaid may lose insurance temporarily because of renewal difficulties.
Enabling: DOH collaboration with Medicaid, PE-MOSAA activities.
Population Based: children and youth with special health care needs who have Medicaid may lose insurance temporarily because of renewal difficulties.
FY03 Report,
Infrastructure Building: CMS provided education and advocacy with Secretary of DOH regarding need for sufficient funding to increase the $15,000 limit for
CMS clients, increase dated hospital per diem rates, increase number of multidisciplinary clinics. The Secretary of DOH has approved the closing of HKF in order to address the need for these changes within the CYSHCN program: increase in the limit for CYSHCN clients to providers, increase hospitals per diem rates, increase in reimbursement for cancer, cardiac and renal conditions. The legislature provided $100,000.00 in funding for cancer treatments. Unfortunately, 1500 non-medicaid eligible children lost primary medical care services when Healthier Kids Fund (HKF) closed. CMS continues to provide leadership in provider and pediatric specialist infrastructure issues as well as access to health care for immigrants.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborative networking with Medicaid's Managed Care Organizations.		X		X
2. Collaborative networking with state agencies, legislative committees to promote universal access funding.				X
3. Promote on-site eligibility/enrollment procedures for children's insurance/Medicaid/S-Chip and other payors.		X		X
4. Monitor and use data for policy and program planning (NM PRAMS, NM BRFSS, CSHCN survey, Medicaid				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct
Enabling: Title V MCH and state general funds are used to cover services for pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of

coverage.
Population Based:
Infrastructure: FHB staff participated in the EPSDT-Medicaid Advisory Committee (emelda). The FHB team worked with partners to identify statewide strategies to address issues of uninsured or underinsured. CYSHCN leadership and partners provided input in to the State Health Plan.
CMS also monitored the implication of the purchasing specifications for CYSHCN that were present in the Medicaid program, and which were carried forward in the redesign of Medicaid and included in the state health planning.

c. Plan for the Coming Year

Direct: DOH continuously aims to reach out to children and families to increase the rate of children who are uninsured. These means include: working collaboratively with community based programs and school based health centers.
Enabling Title V MCH and state general funds are used to cover services for pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of coverage.
Population Based
Infrastructure: Use findings of the NM sample, national Child Health Survey on factors associated with insurance coverage, access to and use of primary preventive care (preliminary findings in needs assessment). An estimated 48,134 NM children age 0-17 have no coverage. Coverage varies by age group. A high proportion of young children age 0-10 years are covered by Medicaid, from 40-55%; the proportion of older children varies from 21-50%. The Medicaid 1115 waiver continues to provide family planning services. Issues such as gaps in services will be monitored include the shortened eligibility periods for children on Medicaid thru the EPSDT Advisory Committee. In addition, a request to include and address issues of immigrant children and youth will continue. The Children's Cabinet will work to address universal coverage for children.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	77	60	61	75	75
Annual Indicator	74.8	77.8	68.8	79.7	80.6
Numerator	235136	263625	249770	269487	272894
Denominator	314250	338915	363169	338146	338489
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	80	80	8	80	80

Notes - 2002

Medicaid data has not been completed and submitted to Title V MCH; will update when it arrives. This is a reasonable estimate

Notes - 2003

Data for FY2002 appear to be under-reported; data for FY2003 appears to be more consistent with previous years. The numerator includes infants and children age 1-20 who received a service. The denominator includes the population estimate for 2002 of infants and children multiplied by 60%. It is estimated that 60% of NM children are at or below 185% of poverty and potentially eligible for Medicaid.

Notes - 2004

Census data is for 2003; 2004 estimates are not available. The target was reset to 80% for next 5 years; the state would aim to hold ground.

a. Last Year's Accomplishments

There is year-to-year variation in the data that one might attribute to obtaining unduplicated counts from a billing system. Known issues from needs assessment: potentially eligible include immigrant children, working poor, families who could but do not enroll in Medicaid, areas of state where
families report difficulties such as unpleasant enrollment processes. Title V MCH will work with Medicaid teams to further explore issues planned achievement for FY03, Infrastructure Building: Activities and results: Three FHB programs work actively to enroll eligible children in Medicaid: Families FIRST Case Management, Children's Medical Services and Family Planning Program; School-based health centers work on this as well. The presumptive eligibility-Medicaid on-site application assistance (PE-MOSAA) procedure is implemented in Local Health Offices and private contractors.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote on-site eligibility evaluation and registration for Medicaid in many sites that serve children.				X
2. Promote use of Medicaid/S-Chip cards by NM Families who are on the program.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Justification for how you set targets from FY04-FY08: previous FHB team members and likely needs to be adjusted, which will be addressed in FY06, set the target. List key factors from

needs/resources assessment that will be addressed: there is a need to assess the situation, which will require collaboration with Medicaid. Planned achievements and activities for FY06, Infrastructure Building: Three FHB programs will continue to work actively to enroll eligible children in Medicaid: Families FIRST Case Management, Children's Medical Services and Family Planning Program; School-based health centers work on this as well. The PE-MOSAA procedure will continue to be implemented in Local Health Offices and by contractors; however because the Medicaid agency has decided not to reimburse for this service, it may be reduced in local health offices. FHB leaders will work with Medicaid leaders to assess the data to understand

c. Plan for the Coming Year

The FHB programs will continue to work actively to enroll eligible children in Medicaid these programs include: Families FIRST Case Management, Children's Medical Services and Family Planning Program.. These programs provide presumptive eligibility Medicaid on site application assistance (PE-MOSAA) which provides assistance to clients maneuver the difficult processes in becoming Medicaid eligible, once determined eligible, assistance is provided in understanding the benefits they are entitled to receive. These services assist with the application process, assisting with the documentation required and the follow-up for either additional information or the status of eligibility. This may include eligibility for children eligible for the State Children's Health Insurance Program (SCHIP) with the goal that eligible children to optimally enhance the health and welfare of children and youth in New Mexico.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1	1
Annual Indicator	1.3	1.1	1.3	1.1	1.1
Numerator	357	301	347	319	303
Denominator	27206	27101	27708	27799	27378
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1	1	1	1	1

Notes - 2003

Note: the provisional report had 291 VLBW infants; the final, after VRHS received the out of state birth information on NM resident infants, there were 319 - a difference of 28 VLBW infants. . NM will try to analyze the data and understand if these were out of state or in-state births.

a. Last Year's Accomplishments

xxxxxxxxxxxxxxxxxxxxxxxxx

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Decrease harmful substance use among childbearing women (tobacco, drugs, alcohol)	X	X	X	X
2. Work to increase early prenatal care.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

xxxxxxxxxxxxxxxxxxxxxxxxx

c. Plan for the Coming Year

2006, Direct Health Care: Continue to partner with clinics and providers and PHD district staff to enhance access to PNC and support PNC in PHOs as needed.
2006, Enabling Services: Continue support and expand sites giving culturally appropriate group PNC in representative communities. Encourage use of these pilots as models to demonstrate to and train more providers in culturally appropriate group PNC.
2006, Infrastructure Building: Produce third annual PHD PNC Conference. Continue and refine the High Risk Fund system of provider agreements to spread access to high risk prenatal care for medically indigent more broadly. Increase communications with and support of UNM maternal/fetal medicine specialists to enable them to establish and maintain more outreach clinics in rural and underserved areas. With Health Systems Bureau personnel to develop statewide plan to increase access to prenatal care. Continue work with midwives to obtain solutions to barriers to practice created by skyrocketing liability insurance rates and absence of liability insurance for out-of-hospital births. Implement new CNM regulations to remove unnecessary barriers to practice such as special application for prescribing privileges and the inability of graduate NMs to practice under supervision while awaiting the qualifying exam and its results. Review and edit the new proposed New Mexico Midwives' Association Practice Guidelines, which serve as detailed protocols for Licensed Midwives. Explore wider provision of prenatal care to remote areas through sharing use of mobile units. Establish public access to prenatal care information through a toll-free number
2006 Population Based Services: Continue, with the multi-agency Prenatal Care Task Force, to seek funds for media campaigns to encourage early prenatal care. Find funding and develop a PNCTF website.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15*

through 19.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14	13.5	13.5	13.5	13.5
Annual Indicator	18.5	14.0	14.8	11.8	23.6
Numerator	27	20	22	18	36
Denominator	145751	143344	148644	152308	152308
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.5	13	13	13	13

Notes - 2003

The number of teen suicide deaths is provisional; the census estimate for the denominator is not final.

Notes - 2004

The target will not be revised; suicide numbers and rates are highly variable from year to year.

a. Last Year's Accomplishments

2004 Direct Health Care: The Bloomfield School District in San Juan County delivered the Signs of Suicide Program that educates students, parents and staff on identification of risk, and surveyed 500 students for risk and had 20 counselors on hand to further address students needing counseling and referral, as part of this process. Eight school based clinics or wellness centers delivered the Columbia Teen Screening process to over 800 students. Three additional sites are trained and preparing to screen next school year. The medical director continued to participate in the development and offering of a summer local arts for boys program, discussing a variety of prevention messages, including issues of suicide. He also helped create a one day men's wellness offering in Silver City which focused on issues of violence and men.
2004 Enabling Services: Worked closely with the Department of Public Safety as they created regulations around the Concealed Carry Weapon permit process, to ensure that part of the educational requirements included a module on youth suicide/ gun violence prevention. Continued public/professional education efforts aimed at increasing proper gun storage practices, with over 850 educational contacts.
2004 Infrastructure Building: Currently the only real funding for suicide prevention in NM consists of $53,000 through funding from the Centers for Disease Control Preventive Health and Health Services Block Grant. This funding currently provides suicide prevention programs and services in four counties. The contract is with the comprehensive program of New Mexico Suicide Intervention Project (NMSIP), and provides warning sign and referral training in schools and in communities, offers technical assistance on community based coalition development and curriculum development, offers counseling services for youth and their families at risk for suicide. NMSIP mainly serves Santa Fe, Rio Arriba, Taos and Sandoval County. They are unable to expand due to limited resources. United Way in San Juan County received $1,500 to enhance the awareness of the problem of suicide through PSAs and media events. NM Suicide

Survivors received $1,200 to provide training for survivors to start their own groups in their local communities. A Suicide Prevention Coalition exists to guide the Public Health Division in addressing gaps of programming within the state and finding resources for prevention activities. The membership consists of agency representatives and community members with direct knowledge of suicide issues. The MCH Medical Director participates in these efforts. Continued to work with MCH councils to increase community-based initiatives related to youth suicide prevention. Continued to monitor suicides through vital statistics and fatality review teamwork.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Use of NM Child Fatality review findings about suicide for policy and program planning			X	X
2. Periodic submissions to newsletters on topics about suicide prevention and reducing stigma of getting mental health services			X	X
3. Suicide prevention training in schools & communities				X
4. School-based Columbia Screening Tool implemented in selected NM Schools.	X	X		X
5. Statewide suicide prevention council addressing community coordination issues.				X
6. Public & professional training sessions, educational or informational opportunities are ongoing.				X
7.				
8.				
9.				
10.				

b. Current Activities

2005 Direct Health Care: Three additional Columbia teen screen sites were trained and started to screen this past school year. By the end of June 2005, twelve of the 89 School Districts have now implemented Columbia teen screen. Men's wellness fall and winter events focused on issues related to men and violence prevention, including suicide, reaching almost 200 men.
2005 Enabling Services: Continued to work closely with the Department of Public Safety as they implemented regulations around the Concealed Carry Weapon permit process, to ensure that part of the educational requirements included a module on youth suicide/ gun violence prevention A monthly E newsletter was established and edited by the Medical Director and sent to violence free youth and suicide prevention coalition members.
2005 Infrastructure Building: The contract continued with the comprehensive program of New Mexico Suicide Intervention Project (NMSIP), and provided warning signs and referral training in schools and in communities, offered technical assistance on community based coalition development and curriculum development, offered counseling services for youth and their families at risk for suicide. NMSIP mainly serves Santa Fe, Rio Arriba, Taos and Sandoval County. They have been unable to expand due to limited resources. A Suicide Prevention Coalition exists to guide the Public Health Division in addressing gaps of programming within the state and finding resources for prevention activities. The membership consists of agency representatives and community members with direct knowledge of suicide issues. The Family Health Bureau (MCH) Medical Director participates in these efforts, and coordinates activities with the Office of School Health. He helped create a "white paper" on the issue of youth

suicide, which led to moving most of the suicide prevention activities to the Office of School Health, for better coordination. This last year also saw the creation of a state youth suicide prevention position, within the Office of School Health. Both the Governor and DOH made youth suicide prevention a priority issue. DOH gave it prominence in its strategic plan, and the Governor organized a Task Force, with subsequent funding of 520 K during this last session; dollars are to be used to increase mental health screenings in primary care, as well as school based clinics, creation of a call in crisis response number for young people, anti-stigma work around access to mental health services, and a variety of strategies to increase the number adolescent mental health providers in the state.of child and

c. Plan for the Coming Year

The youth suicide rate continues to be highly variable, and NM targets are based on national trends which suggest a declining rate of youth violence in general, some minimal improvement in substance abuse use in youth, although the most commonly used drugs, alcohol and marijuana, remain essentially unchanged, and some improvement in our statewide capacity in terms of mental health service delivery. In cooperation with other relevant public health programs, Family Health focuses on raising awareness about the importance of proper storage of firearms, engaging communities in prevention efforts, improving services in school based environments, and monitoring trends through vital statistics and fatality review team efforts.
2006 Direct Health Care: Continue to work closely with the Office of School Health and Injury Prevention EMS Bureau to improve and expand mental health services and screenings offered through school based health clinics. Provide some direct services to programs serving boys in the Santa Fe area.
2006 Enabling Services: Continue public/professional education efforts aimed at increasing proper gun storage techniques. Continue to monitor the effects of the concealed carry law, which began issuing permits January of 2004.
2006 Infrastructure Building: Continue to work with MCH councils to increase community based initiatives related to youth suicide prevention. Continue to monitor suicide trends through vital statistics and fatality review teamwork. Continue to educate the public and professionals about depression and youth suicide through educational conferences, radio, newspaper and television programs. Coordinate with the activities of the statewide suicide prevention coalition. Continue to strengthen the Santa Fe Boy's group, and work to offer Men's Wellness activities throughout the state.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	65	70	71	70	70
Annual Indicator	65.3	60.1	70.6	69.3	77.6
Numerator	233	181	245	221	235
Denominator	357	301	347	319	303
Is the Data					

Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	70	70	70

a. Last Year's Accomplishments

2004 Report of activities Infrastructure Building: Networked and met with UNMH personnel directly involved in preterm labor transport and NICU. Encouraged development and implementation of increased efforts to train rural physicians and hospital staff in rapidly accessing transport for women in
preterm labor. Tocolytics are now known to be ineffective for preventing labor more than 2 to 4 days.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Work to upgrade staff, capacity and systems of transport.				**X**
2. Analysis of linked birth-death data to identify gaps or disparities.				**X**
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2005, Infrastructure Building: Continue networking with personnel involved in NICU, transport and rural hospitals University-operated perinatal outreach clinics are located in Albuquerque at the Indian Health Service, Las Cruces (Mountain View and Memorial/First Step), Alamogordo, Farmington, Taos, and Roswell.. These clinics are staffed by university Maternal-Fetal Medicine sub specialists (perinatologists) and provide ongoing local patient care and physician consultation. For 2002, 627 patients were seen in these clinics. The maternal transport and obstetric referral system provides access to a Maternal-Fetal Medicine sub specialist 24/7 for telephone consultations, at an average of six calls/day, and to accept the transport of patients requiring intensive management at the university, including women in preterm labor. A comprehensive outreach educational program for community-based hospitals, physicians, and staff is manned by Maternal-Fetal Medicine sub specialist physicians, diabetes educators, and clinical nurse educators who travel the state to provide training programs that help to maintain a uniform and ever improving standard of obstetrical care for New Mexicans. High-risk obstetrical programs and case presentations are presented at community hospitals, in which all health care professionals interested in maternal child health may attend. From July 2001 through June 2002, a total of 120 obstetrical outreach educational programs were presented to more than 1600 participants at no charge. All educational programs provide accredited continuing education units for nurses, midlevel providers, and physicians.
The total number of maternal transports was 614 for the 02 fiscal year compared to 635 in

fiscal year 03., an upward trend, even considering the fact that UNM's outreach clinics make some transports unnecessary! Additional funding of the Maternal Health Program's agreement with UNM Maternal-Fetal Medicine to see high risk medically indigent women at no cost to them helped in development of this program.

c. Plan for the Coming Year

2006 Infrastructure Building: . Further expansion of the UNM perinatology outreach program clinics and educational programs. Negotiate with adjacent states to smooth diversion of transports to nearest tertiary care center with neonatal intensive care unit (NICU) with sufficient staff and capacity at the time. 3) Approach Air Force and/or National Guard for assistance with transport vehicles or to carry out transports.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	70	70	71	71	71
Annual Indicator	65.3	65.5	66.0	65.5	65.7
Numerator	17757	17741	18293	18219	17980
Denominator	27206	27101	27708	27799	27378
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	71	71	71	71	71

a. Last Year's Accomplishments

2004, Direct Health Care: Continued support for LHOs in giving PNC to underserved women. Developed and negotiated provider agreement with primary care to give PNC to unserved women in Clovis. Continued previous provider agreements with primary care agencies. Continue to work with the prenatal population to obtain Medicaid eligibility status and early prenatal care through the Families FIRST program

2004, Enabling Services: Pursued establishment of a position for a Health Educator in the Maternal Health Program to strengthen all program activities. Visited most LHO PNC clinics, including new clinics in Truth or Consequences and Lordsburg. Continued Audio Digest, Ob/Gyn Track for LHO clinicians giving PNC. Presented first day-long conference on PNC for PHO clinical staff, with 40 attendants. Continued provider agreements with specialists enabling PNC for high risk medically indigent. Regulations for both CNMs and LMs are being revised to further reduce barriers to CNM prescribing and the connect LMs better with their national credentialing organization. CNM services continue to increase, reaching 30% of deliveries in

2002. Provided technical assistance (TA) to direct entry midwifery association to overcome barriers to accessing Medicaid payments for services. Continue to establish Care Coordinators in PHO's as well as in the private sector to provide Families FIRST services.

2004, Population Based Services: Negotiated, administered and oversaw a contract with an agency to provide training, technical and material support for 8 representative pilot sites throughout the state to initiate culturally appropriate group PNC in LHOs, IHS offices and primary care sites. Continued to develop interagency Prenatal Care Task Force

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Offer prenatal care in local health offices to women who have no other source of care.	X	X	X	X
2. Contractual agreements with clinics to provide prenatal care for medically indigent women.	X	X	X	X
3. Social marketing, media messages to encourage early prenatal care.			X	X
4. Assess marginalized women's needs regarding prenatal care.			X	X
5. Use of NM PRAMS data to identify key factors, gaps and disparities, associated with late entry and low level of care.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2005 Direct Health Care: Continue to partner with clinics and providers and PHD district staff to enhance access to PNC and support PNC in PHOs as needed. Preparations, including equipment and staff training, made to initiate PNC in Clovis and Santa Rosa to provide PNC in communities where it is now unavailable for medically indigent women. However, this program was not started. Instead, a Health Systems Bureau contractor skilled in community development is studying the resources and gaps in prenatal care in Clovis with the expectation of developing a solution based on agreements among current community stakeholders.
2005, Enabling Services: Continue support to 8 pilot sites giving culturally appropriate group PNC in representative communities. Encourage use of these pilots as models to demonstrate to and train more providers in culturally appropriate group PNC. Continue to develop revised CNM and LM protocols to decrease barriers to practice and enhance national participation. Continue TA to direct entry midwives to overcome barriers to Medicaid reimbursement. Legislative action and direct negotiations with Medicaid stakeholders and midwives has moved this situation ahead, with several solution options receiving attention from legislators, Medicaid agencies and the public. A Senate memorial created a task force to study health care liability insurance problems, develop solution options and report to the legislature in November. However, one or two very active birthing centers have been forced to closed because liability insurance is no longer available from any source for out-of-hospital deliveries. . Provide ongoing support, training and technical assistance to Care Coordinators throughout the state regarding high risk pregnancies, and determined possible high risk infants with appropriate referrals and follow up.
2005, Infrastructure Building: Produce second annual PHD PNC Conference. Continue to build

partnerships by strengthening the interagency NM Prenatal Care Task Force. Met with Health Systems Bureau to identify resources, gaps and barriers to prenatal care access.
2005 Population Based Services: NM Prenatal Care Task Force initiated a media campaign to disseminate information to women on how to recognize possible early pregnancy, encouraging early testing and prenatal care, and giving providers tools and encouragement for implementing preconception care.

c. Plan for the Coming Year

2006 Direct Health Care: Continue to partner with clinics and providers and PHD district staff to enhance access to PNC and support PNC in PHOs as needed/ programs such as Families FIRST to enhance access to PNC and support PNC in PHOs as needed

2006 Enabling Services: Continue support to 8 pilot sites giving culturally appropriate group PNC in representative communities. Encourage use of these pilots as models to demonstrate to and train more providers in culturally appropriate group PNC. Continue to develop revised CNM and LM protocols to decrease barriers to practice and enhance national participation. Continue TA to direct entry midwives to overcome barriers to Medicaid reimbursement. Approach one of the MCO's contracted with Families FIRST for casemanagment services to re-instate utilization of Families FIRST services for this population

2006 Population Based Services: Initiate needs assessment for medically indigent pregnant women statewide with MCH epidemiologist. Continue seeking funds with the NM Prenatal Care Task Force for further media efforts.

2006Infrastructure Building: Develop a celebration and publicity event with Maternal/Infant Care Project of UNM. Continue meetings with Health Systems Bureau to gather information and develop strategies to increase prenatal care access. . Continue to work collaboratively with the New Mexico Medicaid Division for early identification of this population and assist with obtaining early prenatal care.

D. STATE PERFORMANCE MEASURES

State Performance Measure 19: *The number of 33 counties adopting the conceptual framework of Healthy Youth/Healthy Communities through an Assets/Resiliency model approach when working with youth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	55%	66%	73%	75	75
Annual Indicator	0.5	0.5	0.5	0.8	0.5
Numerator	18	18	18	26	18
Denominator	33	33	33	33	33
Is the Data Provisional or				Final	Provisional

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	

a. Last Year's Accomplishments

Infrastructure Building: Enhanced the development of the Youth Development Advisory Council (YDAC) to promote youth leadership in planning and evaluation of programs and policies serving youth. Supported operations of the YDAC through youth coordination, statewide trainings, and diverse membership. Networked with community organizations and public/private partnerships to promote a statewide assets/resiliency framework. Trained and conducted outreach focused on fostering developmental assets and healthy sexuality, through planning, evaluation, community organizing, advocacy, and peer education in New Mexico.
2004Results- Goals and objectives for promoting healthy sexuality statewide during 2004 were created by the YDAC during statewide trainings and presented to service providers and youth workers at statewide conferences.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Build on work of Youth Development Advisory Councils to futher create youth involvement in community health coalitions				**X**
2. Training in healthy youth development for all 68 School Health Advisory Councils				**X**
3. Create statewide concensus on definitions used in the new state performance measure proposed for 2006				**X**
4. Maintain and recruit diverse membership in the statewide Youth Development Advisory Council continues.				**X**
5. Partner with state and community agencies to implement best practices in youth development programs.				**X**
6. Note: this measure revised and will continue in next 5 years.				**X**
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building: Created a partnership between the Youth Development Advisory Council and the Governor's Youth Alliance to promote youth leadership in planning and evaluation of policies and programs serving youth and a direct route of communication with the Governor. Networked with community organizations and public/private partnerships to create positive youth development opportunities in communities. This includes a New Mexico Youth Radio Network producing quality radio programming to amplify the voice of youth and their communities concerning issues that affect them. Trained youth as peer educators and conducted outreach focused on fostering developmental assets and healthy sexuality, through a YDAC Day of Action Event, "Reality Check". YDAC members advocated for more comprehensive sexuality education at the statewide YIPES/SHARE Conference. The Adolescent Development Program merged with the DOH Office of School Health and youth

participation on School Health Advisory Councils (SHACs) was written into all FYO6 School-based Health Center contracts.
2005Results-
Goals and objective for promoting healthy sexuality statewide during 2004 were advocated for at statewide conferences and addressed by improved access to reproductive health services through creation of 34 new school-based health centers and identification of an evidence based communication strategy to help adults communicate with teens about risky sexual behavior. New Mexico Youth Radio Network established. Partnership between the Governor's Youth Alliance and YDAC formed.

c. Plan for the Coming Year

Infrastructure Building: Evaluate county health council and tribal health council performance for the 6 critieria proposed for this mesure. Obtain funding for an evidence based communication strategy to help adults communicate with teens about risky sexual behavior. Build on the work of the YDAC by institutionalizing youth involvement statewide. Enhance the capacity of the School Health Advisory Councils (SHACs) to promote youth leadership and involvement in planning and evaluation of programs serving youth through advocacy, peer and elder education. Assist in creation of 34 new and train all 68 School Health Advisory Councils in essential experiences and promising practices of positive youth development. Also train SHACs in how to create the conditions for youth-adult partnerships in shared decision-making and action. Training and outreach will focus on fostering developmental assets for prevention of teen pregnancy, suicide, substance use/abuse, obesity and their antecedents. We will also be working to insure youth involvement with the statewide County Health Councils. Enlist CDC Public Health Prevention Specialist to assist in convening key stakeholders in creating a shared statewide definition of positive youth development and essential defining features, and a system to capture statewide efforts at promoting positive youth development. The program will work to coordinate efforts with Governor's Youth Alliance and the Children's Cabinet to create a public health subcommittee as an avenue to address policy and system changes.

State Performance Measure 20: *Percent of first newborns/moms receiving support services/parenting through community home visiting/support programs*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	14	16	18	26	26
Annual Indicator	26	26	11.7	9.7	9.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	9.7	10	10	10	10

Notes - 2002

The state has limited capacity to report on this indicator; NM PRAMS data is used; PRAMS reports on if the mother had home visiting services and NOT on the nature of the services. During the comprehensive assessment years (FY2004-2005) NM may work on obtaining a more accurate estimate for this important indicator.

The data were updated June 2005; PRAMS estimate for post partum home visiting, first time mother is used: = 11%

Notes - 2003

The PRAMS estimate of 4.3% is much lower than previous years. This data needs to be checked.
The state has limited capacity to report on this indicator; NM PRAMS data is used; PRAMS reports on if the mother had home visiting services and NOT on the nature of the services. During the comprehensive assessment years (FY2004-2005) NM may work on obtaining a more accurate estimate for this important indicator.

The data were updated June 2005; PRAMS estimate for post partum home visiting, first time mother is used: = 9.7%

Notes - 2004

The state has limited capacity to report on this indicator; NM PRAMS data is used; PRAMS reports on if the mother had home visiting services and NOT on the nature of the services. During the comprehensive assessment years (FY2004-2005) NM may work on obtaining a more accurate estimate for this important indicator.

The data were updated June 2005; PRAMS estimate for post partum home visiting, first time mother is used: = same as 2003, PRAMS data for 2004 will be available end 2005.

a. Last Year's Accomplishments

2004 performance indicator & target: NM PRAMS measures if any home visiting was received & if any parenting classes were attended; the estimates for 2001-2002 were as follows: For combined birth years 2001-2002, 5.1% of women with live births received prenatal home-visiting services, and 17.7% of women participated in prenatal parenting classes. Postpartum, 8.5% of mothers received home visiting services and 5% participated in parenting classes.
Of women with no previous live birth, 5.5% received prenatal home- visiting services and 30.3% participated in prenatal parenting classes.
Postpartum, 11.3 % of women with no previous live birth had home-visiting services, and 6.4% participated in parenting classes.. 2004 Target:14%
2004, Enabling Services: The program provided parenting education and support services to 25 families of newborns.
2004, Infrastructure Building: Interagency partnership for implementation of the Infant Mental Health Strategic Plan resulted in the Children, Youth and Families Department statewide assessment of agency services, capacity, and awareness of the important of infant mental health.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Continue to strengthen home visiting services in Las Cruces and Santa Fe				X
2. Partner with state and community agencies to Improve access to primary prevention home visiting services.				X
3. Work with Children's Cabinet and Children Youth & Families Department to strengthen home visiting programs				X
4. Participate in the implementation of the Infant Mental Health Strategic Plan for New Mexico.				X
5. Continue support for the Las Cruces Public Schools primary prevention home visiting services as a model.				X
6. Address appropriate home visiting issues through the MCH Early Childhood Comprehensive Systems Grant				X
7. Note: this measure refined and will continue next 5 years.				X
8.				
9.				
10.				

b. Current Activities

2004, Planned Achievement Enabling Services: Observe and enhance the home environment and parent child interactions by providing parenting education and support services through home visiting. Results-Title V supported a home visiting contract to provide parenting education and support services to 25 families of newborns in Las Cruces. 2005, Planned Achievement Infrastructure Building: Partner with state and community agencies to implement the Infant Mental Health Strategic Plan for New Mexico.
Results-Although activities were reduced because of a position that was vacant for the entire year, Title V staff attended the Georgetown Infant Mental Health Academy as part of a team that included state and community agencies with follow up to implement the training goal of the Infant Mental Health
Strategic Plan; promoted best practice in primary prevention home visiting through interagency partnership; integrated discussion of home visiting into activities of the Early Childhood Comprehensive Systems Grant.

c. Plan for the Coming Year

2006 Planned Achievement Enabling Services: Shift Child Health funds to maintain the Las Cruces Home Visiting contract to make up for the Department budget cuts.
2006 Planned Achievement Infrastructure Building: Fill the Child Health Educator position and provide staff development as needed to assure knowledge, skills, and abilities to provide Title V leadership in public health assessment, assurance, and policy development ; Partner with state and community based agencies to implement the Infant Mental Health Strategic Plan Training Goal; Promote best practice in primary prevention home visiting; Integrate identified home visiting priorities into the work of the Early Childhood Comprehensive Systems grant.

State Performance Measure 21: *Reduce unintended pregnancy in New Mexico to less than 30% of births*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	45	45	45	43	42.5
Annual Indicator	43.6	42.2	42.2	42.2	41
Numerator					
Denominator					
Is the Data Provisional or Final?					Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	42.5	42.5	42	42	

Notes - 2002

NM PRAMS, 1999 and 2000 found 43.6% (CI 41.0, 46.2) of pregnancies resulting in live birth were unintended. The 2001 data will be available by December 2003; 2002 data by June 2004.

Notes - 2003

Estimate based on 2000-2001 NM PRAMS data. Data for 2002 will become available in fall 2004.

Notes - 2004

NM PRAMS estimate for calendar 2003 is reported in 2004

a. Last Year's Accomplishments

Direct Health Care:
1) Increase services to hard to reach populations- Result: Local health offices distributed 126,773 flyers, 8 PSAs, 4 Newspaper/Media Articles, 4 Posters, and participated in 28 Health Fairs where hard to reach clients (adolescents, homeless, males, incarcerated individuals) were educated.
2) Expanded services- Result: The Family Planning Program added 24 Provider Agreement sites. 1,910 clients were served during flex hours at local health offices, 572 clients were served in mobile vans.

Enabling Services:
Target outreach efforts for adolescents- Result: 40 offices provided outreach through local high schools, mobile van unit, community colleges, alternative high schools, family related organizations and youth groups.

Population Based Services:
Provide outreach and education in local public health offices- Result: 1,458 received family planning education through educational contacts. Local health offices provided educational sessions at 320 community sites, 52 civic organizations, and 56 religious sites. 1,059 teens received family planning education.

Infrastructure Building:
1) Ensure quality assurance through training, client surveys and EMA (Standards of Care, Best Practice, and Client Centered Care)- Result: A yearly client satisfaction survey is distributed to local public health offices. Family planning provided 47 trainings with a total of 1,425 participants.

2) Develop community networks- Result: Networking with 84 local physicians, 60 health councils, 16 MCH councils, 16 religious organizations, 276 school-related contacts, and 52 detention center contacts. 1385 teens were reached through community networks.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Inform public of available family planning services through collaboration with resources such as STD				X
2. Increase and maintain existing community networks by partnering with providers, schools, First Choice				X
3. Develop creative outreach activities for FP; increase cultural awareness and sensitivity activities.				X
4. Establish or enhance clinical services by expanded hours, days, walk-in services, mobile vans				X
5. Use of NM PRAMS data to identify factors associated with unintended pregnancy, for use in policy & program planning				X
6. Note: this measure to continue in next 5 year period				X
7.				
8.				
9.				
10.				

b. Current Activities

Direct Health Care:
1) Increase services to the adolescents- The total number of adolescents seen at clinics for family planning services is 6422, 5794 females and 628 males.
2) Expanded services- Result: 2,366 clients were served during flex hours at local health offices, 233 clients were served in mobile vans.

Enabling Services:
Target outreach efforts for male and female adolescents- Result: 40 offices provided outreach through local high schools, mobile van unit, community colleges, alternative high schools, family related organizations and youth groups.

Population Based Services:
Provide outreach and education in local public health offices- Result: 598 received family planning education through educational contacts. Local health offices provided educational sessions at 177 community sites.

Infrastructure Building:
1) Ensure quality assurance through needs assessment, client surveys and EMA (Standards of Care, Best Practice, Client Centered Care)- Title X Family Planning conducted a state-wide needs assessment on reproductive health services among women of reproductive age in NM, continue to analyze and report NM PRAMS data for teens age 15-17 and age 18-19; with presentation of data to target groups.
A yearly client satisfaction survey is distributed to local public health offices. Family planning provided 47 trainings with a total of 1,425 participants.

2) Develop community networks- Result: Networking with 464 local physicians, 248 health councils, 70 MCH councils, 61 religious organizations, 113 school-related contacts, and 169 detention center contacts. 3891 teens were reached through community networks.

c. Plan for the Coming Year

Direct Health Care:
Increase services to the hard to reach population
Expanded services
Enabling Services:
Target outreach efforts for hard to reach populations such as incarcerated, homeless, domestic violence victims and males.
Population Based Services:
Provide outreach and education in local public health offices
Infrastructure Building:
1) Ensure quality assurance through needs assessment, client surveys and EMA (Standards of Care, Best Practice, Client Centered Care)- Continue to analyze and report NM PRAMS data with presentation of data to target groups.
2) Develop community networks

State Performance Measure 22: *Reduce the number of children witnessing violence (exposed to domestic or sexual violence) as expressed by percent of children present at a domestic violence scene.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15	15	14	14	13
Annual Indicator	16.09	14%	14	14	14
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	13	13	13	13

Notes - 2002

The 2002 estimate of 14 percent of NM children who are present at a domestic violence event is from police reporting from the NM domestic violence project. In 2000, NM PRAMS estimated that 12.6% of the birth population was potentially exposed to physical abuse of NM mothers by their partners.

Notes - 2003

The data for this year has not yet been released; NM reports the same estimate as for last year as a very provisional number.

Notes - 2004

The 2004 estimate of 14 percent of NM children who are present at a domestic violence event is from police reporting from the NM domestic violence project.

a. Last Year's Accomplishments

2004: Key factors from needs/resources assessment that were to be addressed included continuation of coalition building around domestic violence prevention, continuation of sexual assault prevention activities and expansion of SANE programs.
2004 Direct Health Care: Medical director provided 6 week support group for boys in an elementary school, many of whom were exposed to violence in their homes.
2004 Enabling Services: 300 copies of Stolen Childhood video distributed to mental health and community agencies for use in trainings and direct counseling with offenders. Monthly E newsletter, with statewide distribution, started to educate about resources and research related to DV and sexual violence prevention issues in New Mexico. In Nov 2003, a cross training curriculum for DV and sexual assault providers was published, and regional trainings completed. Medical Director participated in these efforts.
2004 Infrastructure Building: The new statewide coalition, called "The Network, working to end domestic and sexual violence in New Mexico" was strengthened through ongoing meetings; the old Domestic Violence Advisory Council was fully transitioned into this new group. This group complements and supports the work of the two separate existing coalitions against domestic violence and against sexual assault, and has broader representation than either of those groups. A number of legislative successes included more funding for batterer treatment programs (a fee on convictions), and 1 million dollars for funding to prevent sexual violence.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the number of SANE sites				X
2. Cross training for domestic violence & substance abuse provider & program communities				X
3. Strengthen "The Network" (the domestic violence & substance abuse coalition)				X
4. Continue to create the coalition's agenda for working on children exposed to violence				X
5. Work with young men directly through school based program				X
6. Note: this measure will continue in next 5 year period				
7.				
8.				
9.				
10.				

b. Current Activities

In September 2003, the NM Interpersonal Violence Data Central Repository released an updated report, "Sex Crimes in NM". 19% of NM's adult women have been raped at least once in their lifetime. One third to one half of those who were sexually abused as a child experienced a second sexual assault at an older age. 54% of reported non-penetration sexual crimes and

45% of reported penetration crimes (the tip of the iceberg) were perpetrated upon children, 12 and under. More than 100 children were present when a criminal sexual penetration occurred in another family member. A report released July 2004 on Domestic Violence showed 25,644 cases of domestic violence in 2003 as reported by law enforcement, a rate of 14.7 domestic violence incidents per 1000 persons, slightly decreased from a 2002 rate of 15.8 incidents of domestic violence. In 58% of domestic violence incidents, children were present.. This is a 4% increase in reported incidents with children present from 2002, and a 10% increase in reported incidents with children present from 2001.There were 5,543 children present at the scene of their family violence episodes in 2003. There were 5,757 children seeking services from DV service providers, a 6% increase from 2002.
Direct Health Care: Sexual Assault Nurse Examiner activities continued to expand in the state. Since July 2004 to present, a total of eight programs were supported by the Coalition, four of which are new this year. There are now 46 New Mexico SANE-trained nurses with agreements with the Coalition to conduct SANE exams and bill the Coalition. There are eight SANE Programs (Clovis, Portales, Santa Fe, Alb, Las Cruces, Alamogordo, Roswell and Farmington). There is an IHS program in Shiprock that provides sexual assault prevention outreach training to schools through the efforts of the Coalition of Sexual Assault Programs.
Enabling Services: Medical Director helped write the final recommendations for the Governor's DV Task Force, concerning children exposed to violence. Monthly E newsletter on violence related issues continues to be produced and distributed, as do reports on the status of boys for the Santa Fe Boys newsletter.
Population Based Services: Men's wellness activities/ have focused on male violence prevention. Many trainings/articles were presented during the year on preventing DV.
Infrastructure Building: Cross trainings for domestic violence and sexual assault providers occurred. Worked to support/strengthen "The Network" by providing training for the group, writing a "white paper" on the issue, highlighting the needs of children exposed to violence. Legislative briefing given, and at a Senator's request, the Medical Director wrote a Senate Joint Memorial, which passed. The Memorial mandates that appropriate state agencies/ service providers assess the situation with regards to children exposed to DV and make recommendations to a legislative interim committee in fall 2005.

c. Plan for the Coming Year

2006: Direct Health Care: Continue to work towards expanding SANE activities in the state. The communities of Grants, Carlsbad and Deming have one SANE-trained nurse and are working on getting a program going. Continue to utilize men's wellness activities in the state to deliver direct violence prevention messages to the men involved in those programs.
2006: Enabling Services: Continue to provide a monthly E newsletter devoted to prevention of violence, primarily sexual assault and domestic violence, that highlights studies relevant to the effects on children of exposure to violence.
2006: Population Based Services: Provide more outreach to men, helping to educate them and enroll them as part of the solution in the struggle against violence.
2006 Infrastructure Building: Continue to expand the activities and outreach of the Network. Continue to assist the NM Interpersonal Violence Data Central Repository in obtaining more accurate data from Law Enforcement. Work on Senate Joint Memorial 53, which focuses on children and DV.

State Performance Measure 23: *New Mexico's Pregnancy Risk Assessment And Monitoring System (PRAMS)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7	6	6	7	7
Annual Indicator	6	7	7	7	7
Numerator	6	7	7	7	7
Denominator	7	7	7	7	7
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	7	7	7	7

a. Last Year's Accomplishments

Infrastructure Building:
1) Funding support: no change, continues Title V MCH Block Grant, CDC PRAMS Cooperative Agreement and revenues from Medicaid (state portion of expenditures)
2) Steering Committee: Met 3 times; used committee to promote use of 2000 data report; special reports.
3) Full operations: no changes anticipated; new version of PRAMTrack installed late 2003; majority of effort this year devoted to developing and testing new state questions, contributing to national group's efforts on core questions. The new questionnaire used with 2004 births. Will have data on maternal depression, infant car seats, awareness of emergency contraception, food security/insecurity, more information about breastfeeding continuation, more on home visiting.
4) 70% Response rate: no changes anticipated; introduced a telephone calling card of 20 minutes as the incentive.
5) Annual Surveillance Report: 2001-2002 combined data report came out April 2005 (not December 2003 as planned.
6) Special Reports: focus this year was on Medicaid MCO's
7) Data used for policy, program and education: work with MCO's and Families FIRST to improve performance on several indicators among the Medicaid clientele. Work with FHB team to use 1997-2001 PRAMS data for the comprehensive assessment of the Title V MCH Block Grant.
* Special activities: Plan for Dr. Ssu Weng to work with UNM's MPH program to use NM PRAMS data for classroom instruction in analysis of data from complex survey was postponed to summer 2005.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Collect monthly sample, achieve 70% response rate				**X**
2. Produce surveillance report for 2001-2002 data, released April 2005; formal release July 2005; and some 2003 data incorporated in new				**X**

reports				
3. Produce one special report per year: this year teens, Medicaid paid, US-Mexico Border Counties, WIC & non-WIC				X
4. Provide ongoing data reports to data clients in DOH, other agencies, community groups, tribal community				X
5. Train students, professionals in analysis & use of PRAMS data; includes creation of PRAMS database for use in MPH epi course at Univ New Mexico				X
6. Provide data-use consultations to state, community, tribal groups				X
7. Produce special reports for Title V MCH Block Grant, DOH strategic plan, Title X Family Planning, Medicaid, WIC				X
8. Create indicators for NM Children's Cabinet, report card 2004-05, based on Healthy Birth Index from NM PRAMS				X
9. Create & maintain NM PRAMS website thru the DOH website with links to key MCH programs & data sites				X
10. Note: this measure will not continue; subsumed in health measures that depend on PRAMS surveillance for coming 5 year period				X

b. Current Activities

Planned achievement for 2004-2005, Infrastructure Building, Planned Activities
1) Funding support: no change, continued Title V MCH Block Grant, CDC PRAMS Cooperative Agreement and revenues from Medicaid (state portion of expenditures).
2) Steering Committee: Will meet 2-3 times; use committee to promote use of 2000, 2001, 2002
data reports and special reports; work with committee to explore response rate options.
3) Full operations: new staff! Eirian Coronado joined project as Coordinator-Epidemiologist. Phase 5 new questionnaire in the field; large new initiative was to prepare for implementation of computer assisted telephone interviewing (CATI).
4) 70% Response rate: no changes anticipated;
5) Annual Surveillance Report: 2001-2002 data report to came out April 2005; a large project that includes over 21 special topics with detailed analysis by age, race-ethnic, marital, poverty, payor of c are and other indicators; and multi-year analysis 1997-2001.
6) Special Reports: focus this year included data for teen pregnancy and county level estimates.
7) Data used for policy, program and education: PRAMS data used for new Children's Report Card of the NM Children's Cabinet. Will work with MCO's and Families FIRST to improve performance on several indicators among the Medicaid clientele. Worked with FHB team to use 1997-2002, 2003 PRAMS data for the comprehensive
assessment of the Title V MCH Block Grant - extensive use for needs assessment - and development of new measure on physical abuse during pregnancy.
* Special activities: Dr. Ssu Weng to continue work with UNM's MPH program to use NM PRAMS data for classroom instruction in analysis of data from complex survey = near success, data release procedures completed June 2005.

c. Plan for the Coming Year

Planned achievement for 2005-06, Infrastructure Building, Planned Activities
1) Funding support: hope to be successful in application for new cooperative agreement for period 2006-2011; no change, continued Title V MCH Block Grant, CDC PRAMS Cooperative Agreement and revenues from Medicaid (state portion of expenditures).
2) Steering Committee: Will work with committee to develop new 5-year proposal and to

promote use of 2000, 2001, 2002 data reports and special reports; work with committee to explore response rate options.
3) Full operations: no changes anticipated but did appear afterall; new version of PRAMTrack installed
late 2003; Phase 5 new questionnaire in the field; large new initiative was to prepare for implementation of computer assisted telephone interviewing (CATI).
4) 70% Response rate: no changes anticipated but special efforts will be undertaken to increase response rates for selected geographic areas and population groups that have 60-69% response rates;
5) Annual Surveillance Report: 2001-2002 data report to came out April 2005; 2003 estimates produced and 2004 weighted data set will come in. Will develop new format for reporting that will be based on input by current data users at state, local and special advisory committee levels.
6) Special Reports: this will be a grant writing year; reporting for 2003-2004 will be descriptive, some detailed tables.
7) Data used for policy, program and education: work with MCO's and Families
FIRST to improve performance on several indicators among the Medicaid clientele.
Work with FHB team to use 1997-2001 PRAMS data for the comprehensive
assessment of the Title V MCH Block Grant.
* Special activities: Dr. Ssu Weng to continue work with UNM's MPH program to use NM PRAMS data for classroom instruction in analysis of data from complex survey = near success, data release procedures completed June 2005.

State Performance Measure 24: *The state Title V program has a coordinated program of maternal, fetal, infant and child death review*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4	4	4	3	3
Annual Indicator					
Numerator	2	3	3	3	3
Denominator	4	4	4	4	4
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2				

Notes - 2003

The state Title V program has a coordinated program of maternal, fetal, infant and child death review. We do not have, nor do we anticipate having, resources to conduct FIMR/fetal death review. Thus our index of 4 forms of review is shortened to 3 forms of review.

a. Last Year's Accomplishments

Last Year, end Sep 2004

Key factors from needs/resources assessment: Vital Records reports provide mortality data by age, gender, E-code and diagnosis, geo residence. CFR provides insight into risk reduction, prevention or systems improvement factors that may prevent future deaths in the MCH population. NM mortality rates for intentional and unintentional injuries are very high.

Targets were on track however main activity was database development: A consultant was hired to assist coordinator in developing database to track case status, link OMI, VR and panel information, and analyze CFR and MMR data for special and annual reports. Contract services were interrupted 4 months in FY03 with subsequent delays in database development and suspension of some CFR panels for several months. A media consultant was hired to assist CFR and PRAMS to highlight community issues and prevention strategies in articles appearing in community newspapers written in coordination with local MCH councils.

Planned achievements, activities and results for FY03, Infrastructure Building:

1. MMR and CFR fully functioning with chairs, co-chairs and membership.
2. MMR and CFR panels fully abstracted and reviewed one years worth of cases.
3. Data produced for MMR co-chair to present findings from MMR data (1996-2002) at OB/Gyn conference: pregnancy-related and pregnancy-associated deaths in NM; demographic and cause of death distribution.
4. Data produced for chair of CFR Child Abuse & Neglect (CAN) panel to present findings (1997-1999) at Child Abuse and Neglect conference.
5. CFR annual report printed, released, and distributed; highlighting effective prevention programs in NM.
6. CFR subpanel developed to review overdose deaths of children/youth ages 18-24. 7. CFR database completed: case tracking, data entry and data analysis components. 8. Developing similar MMR
database. 9. MMR special report on adult, infant and child restraint use in fatal MVCs of women within one year of pregnancy termination. 10. Data produced for NM Firearm Safety Task force on distribution and characteristics of firearm deaths of NM children. 11. Contracts in place for program assistant in CFR/MMR at 32 hours/week; to develop MMR and CFR database; and media consultant to implement media outreach project for CFR. 14. CFR assisted local MCH councils to write 12 press releases for community newspapers on MCH issues based on data from CFR annual report and PRAMS surveillance report. 15. Instituted protocols and procedures to become HIPAA compliant.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain activities of CFR panels: child abuse & neglect, transportation related, other unintentional injury related				X
2. Strengthen suicide panel, as suicide is a state DOH priority				X
3. Finalized testing of CFR and of MMR electronic database for tracking new case file completion and data reporting for all cases				X
4. Suspend activities of NM CFR and MMR February 2005, lost staff. CFR to be transferred to Injury Epidemiology in coming year.				X

5. Review MMR situation; find appropriate and feasible means to continue MMR in coming year.				X
6. Note: this measure discontinued. Child Fatality Review transferred to Injury Prevention Program, Epidemiology Division				X
7.				
8.				
9.				
10.				

b. Current Activities

Report for period ending June 2005:
Key factors from needs/resources assessment: Vital Records reports provide mortality data by age, gender, E-code and diagnosis, geo residence. CFR provides insight into risk reduction, prevention or systems improvement factors that may prevent future deaths in the MCH population. NM mortality rates for intentional and unintentional injuries are highly varied with a modest downward trend in unintentional.

The main activity was database development: A consultant was hired to assist coordinator in developing database to track case status, link OMI, VR and panel information, and analyze CFR and MMR data for
special and annual reports. Contract services were interrupted 4 months in FY03 with subsequent delays in database development and suspension of some CFR panels for several months; this continued throughout 2004-2005; the program assistant on contract was absent more than 3/4 of the year.
No media consultant was hired to assist CFR and PRAMS to highlight community issues and prevention strategies in articles appearing in community newspapers written in coordination with local MCH councils, due to difficulties cited above.
Planned achievements, activities and results for year ending June 2005 Infrastructure Building:
1. MMR and 3 of 5 CFR panels with co-chairs and membership.
2. MMR and 3 of 5 CFR panels fully abstracted and reviewed one years worth of cases.
3. Due to lack of staff and contractors, no CFR annual report was produced; the data base was populated with information from some panels.
4. The CFR database was completed: case tracking, data entry and data analysis components.
8. Developing similar MMR database.
5. Planned contracts did not get processed by state on timely basis. Contracts in place for program assistant in CFR/MMR at 32 hours/week; to develop MMR and CFR database; and media consultant to implement media outreach project for CFR.
6. Instituted protocols and procedures to become HIPAA compliant.

c. Plan for the Coming Year

Due to loss of staff and transfer of NM Child Fatality Review to the Division of Epidemiology and Response, this measure was retired as of June 2005.
The Title V MCH epidemiology program will explore needs and resources for continuation of NM maternal mortality review.

State Performance Measure 25: *The state has a program for Birth Defects Prevention and Surveillance*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8	8	8	4	4
Annual Indicator					
Numerator	5	8	8	3	3
Denominator	8	8	8	4	4
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3				

Notes - 2002

The NM Birth Defects Prevention and Surveillance System (BDPASS) was fully functioning in 2002; in 2003, due to loss of staff the surveillance function was not completed; it will take one-two years to create and fill an epidemiologist position to do this work. The data base supporting BDPASS is being re-built; the work is expected to be done in FY04. Nevertheless, prevention functions continue.

a. Last Year's Accomplishments

Direct Services, pre-conception genetic counseling/folic acid distribution: 14 families that had an NTD-affected pregnancy received counseling and folic acid supplements purchased with funds from the March of Dimes.

Infrastructure:
1. Passive data linking, birth file to 3CR: 2001 birth files linked to existing 3CR files. Extremely poor data quality encountered; modifications will be made in FY05.
2. Active surveillance: abstracting continued; protocols reviewed and necessary modifications identified.
3. Folic acid/birth defects prevention initiatives: Folic acid publications were mailed out when requested. Additional folic acid educational materials were incorporated into LLH module.
4. Other pre-conception health/birth defects prevention initiatives: LLH pre-conception health education pilot project carried out in 3 NM counties. 400 women completed surveys before and after education interventions. Analyzed surveys demonstrated gain in knowledge and gain in motivation to change behaviors identified as increasing risk for birth defects.
5. Fully staffed (position or contract) with epidemiologist, data manager/programmer, abstractors, and grant manager who also provides prevention education services: CDC/CSTE MCH Epidemiology fellow, Tierney Murphy, MD, MPH, assigned to NM for 2 years. She will work to strengthen and guide the surveillance system, write reports, and present findings to varied audiences. Program will submit position creation for programmer/data manager in July 2004.
6. Adequate funding and resources: Existing funding was redirected to create the data management position

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Maintain active and passive surveillance, including database entries, for selected birth defects (NTD, Orofacial cleft,gastroschisis and heart.				X
2. Produce annual birth defects surveillance estimates; completed for 2001-2002; data collection and cleaning for 2003				X
3. Provide ongoing support for Birth Defects prevention initiatives with focus on people who were trained to use Lifelong Happiness prevention materials in communities.				X
4. Provide genetic counseling and folic acid to mothers who had an NTD-affected pregnancy with federal birth defects grant funded contract at UNM				X
5. Abstractors collect data to contribute to the Birth Defects Prevention and Surveillance System				X
6. Support genetic counseling at Dysmorphology & Genetics Clinics via CMS program	X			
7. Work to improve data collection and database used for birth defects, continued throughout year;				X
8. Applied for competitive birth defects grant; approved but not funded; CMS no longer has funds to support this work;				X
9. Note: this measure discontinued, state does not have sufficient resources in coming years to continue the work.				X
10.				

b. Current Activities

Year ending June 2005:
Direct Services, pre-conception genetic counseling/folic acid distribution: Families that have an NTD-affected pregnancy wereoffered the opportunity to receive counseling and folic acid supplements purchased with funds from the March of Dimes.

Infrastructure: A CSTE-CDC MCH Epidemiology fellow arrived March 2004; birth defects surveillance was a high priority. A position was to have been created to conduct the surveillance, manage and analyze data and do reporting and contribute to birth defects needs assessment. Although CMS program did fund positions in past; these were discontinued. Federal funds were available but posit
1. Passive data linking, birth file to birth defects data from hospitals and providers: Create new database for birth defects. Link 2002 birth file to birth defects database. Monitor coding of birth defects and perform routine quality checks of data. Strengthen passive surveillance system by working with the NM hospitals (data sharing agreements with each of them are in place) and the Health Policy Commission to obtain hospital inpatient discharge data and by increasing hospital and health care provider awareness of birth defects reporting requirements.
2. Active surveillance: Continued abstraction with modified protocols and improved abstracting forms and targeting of surveillance sites to capture high priority birth defects in NM.
3. Folic acid/birth defects prevention initiatives: this continues via WIC programs and needs to become part of women's health care
4. Other pre-conception health/birth defects prevention initiatives: Partnered with WIC to continue distribution of LLH modules in their core curriculum. Continue coaching support and advanced training in motivational interviewing to organizations that participated in the pilot project. Discussed ways to work with March of Dimes to align with their new focus on reducing low birth weight babies.
5. Not Achieved = Fully staffed (position or contract) with epidemiologist, data

manager/programmer, abstractors, and grant manager who also provides prevention education services: CDC/CSTE assignee with state through March 2006. Plan to create and fill position for data manager/programmer.
6. Adequate funding and resources: Anticipated budget cuts will impact contracted abstractors in surveillance activities funded in part by CMS. NM will applied but was not funded for new 5 year competitive cooperative agreement.

c. Plan for the Coming Year

Infrastructure:
Without staff and funds for abstracting, birth defects surveillance is in jeopardy for NM. A special project to evaluate cleft-lip and palate through the enviornmental epidemiology program will be implemented under guidance of Maggi Gallaher, MD, MPH, a deputy state epidemiologist and pediatrician - using carry over funds from the final year of the birth defects federal grant.

State Performance Measure 26: *The Prevalence of Childhood Overweight & Obesity*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10	10	10	10	10
Annual Indicator	9.7	10.1	10	10	10
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	9.5	9.5	9.5

Notes - 2003

State Performance Measure 26 (8). Prevalence of overweight and obesity among children age 0-5. Data for numerator and denominator are not available at this time. We will edit the form when the PEDNES (CDC) data are available.

Notes - 2004

data has not been forthcoming from CDC PedNSS on children 0-5; the state has no reason to think the percentage has changed, indeed in the present environment, the percentage of children 0-5 who are overweight and obese may have increased.
NOTE: this measure will be revised for period 2006-2009; the state will monitor and report on youth in high school from the YRRS, using self report height and weight and a BMI calculation.

a. Last Year's Accomplishments

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FHB programs collaborate with state obesity grant, located in Chronic Disease Program				X
2. WIC program works to promote breastfeeding and appropriate feeding practices of infants and toddlers, towards healthy food habits				X
3. State Title V program using youth risk data, PRAMS data and WIC data to work on plans to address reducing risks of overweight & obesity				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

c. Plan for the Coming Year

E. OTHER PROGRAM ACTIVITIES

Early Childhood Comprehensive Systems Grant: New Mexico Title V Program is developing a comprehensive State-level multi-agency service system, which reaches to the community-level and will support families in fostering the healthy development of their children. There is a crucial need for early childhood systems alignment and integration in New Mexico. New Mexico service systems can better serve families by removing system barriers through cross-agency early childhood systems development planning. The Early Childhood Comprehensive Systems (ECCS) grant is an important opportunity to supplement this systems development work of the State Title V Program.

New Mexico's ECCS planning project has, after two years of work, resulted in a Comprehensive Plan for Early Childhood that includes the following twelve required content areas including: an environmental scan, a vision and mission statement, five priority areas of focus, goals and objectives with timeframes for completion, a set of indicators to track early childhood outcomes; documentation of the strategic planning process with stakeholders, identification of best practice, evidence-based models; identification of key partners, linkages to other State initiatives, evidence that the planning process is positioned to maximize the greatest policy impact; a sustainability plan for the follow up implementation phase, and strategies to strengthen data collection and make system improvements. The Children's Cabinet has supported this work and it has provided input across 12 state agencies to achieve identified policy improvements for infants, toddlers, young children and their families. During the process, important relationships were formed across state agencies and between state agencies, the provider population and families. The basic infrastructure now set up will support development and alignment activities as the objectives of the project are implemented.
WIC/MCH data sharing initiative: The Title V Director and the MCH Epidemiologist are commencing discussions with the National WIC Director to facilitate the sharing of WIC data in MCH settings. The National WIC Director has been invited to an Atlanta meeting to speak to the MCH data community

about WIC regulations, confidentiality and opportunities for data sharing.

F. TECHNICAL ASSISTANCE

Requested leadership training for Title V MCH program's management team, see form 15.

V. BUDGET NARRATIVE

A. EXPENDITURES

V. BUDGET NARRATIVE

A. Expenditures

Significant Year to Year Expenditure Variations:

In the fiscal year 2004, the expenditures for services for children and adolescents as well as children with special health care needs are higher than the required percentages. The amount expended toward services to children and adolescents represents approximately 46 percent of the total MCH federal budget. The amount allocated toward children with special health care needs represents 36 percent of the federal budget. Sixteen percent of the total was spent on women out of the federal budget. Overall, the amount allocated toward children and adolescents, including the state funding equals 45 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 41percent. The amount spent on mothers represents 12 percent of the entire budget.

There is only one significant variation in expenditures from FY2003 to FY 2004. The grant state match amount has been met and there is significantly more state funds expended on MCH services for safety net services such as High Risk Prenatal Care Fund, Maternal Health, and Children with Special Health Care Needs during FY2004. The reason for this was partly because of the Governor reinstituting the Healthier Kids Fund which serves healthy children for primary care, glasses, and dental care. State fund overmatch was used to provide for this need. This may not occur next year with funds as short as they are. The current administration has indicated that they will expend within the Public Health Division budget for the FY2005, an improvement over last year.

Due to the assessment process this year, it became evident through analysis of expenditures over the past few years, that the grant is being spent more and more on direct services due to several factors. First, there are Medicaid cuts happening in the state, and secondly, there is a great influx of undocumented immigrants coming to the State. Lack of federal support for these increased expenditures has required the state to supply an increased amount for direct services, thus depleting state funds for population based services. The federal grant was reduced by $28,695.00 from 2003 to 2004. The same year, the State had to increase the amount it spent to provide the same services to the same populations by an overall increase of $116,493.90. While the Public Health Division set the Title V budget assigned at $210,000.00 less than 2003, it became evident during the year that an overall increase was necessary to meet expenditures for the needs of the citizens and the Governor intervened and increased the state amount allowed for services. The new administration has lengthened the time it takes to contract with providers. Although the Bureau applied for expansion of state funding for children with special health care needs, that request was denied. Costs are still escalating for serving children with special health care needs. The flat budget for the CMS Program over the last few years resulted in increased pressure from the hospitals to increase per diem rates for hospitalized children and youth. The Healthier Kids Fund Program has been level funded since 1999 resulting in extremely limited enrollment of approximately 1500 children. The cost to serve children under this program was less than $300.00 per child per year. Unfortunately, the $100,000.00 legislated last year for children with cancer was not renewed this year. The new administration has also indicated insufficient funding the cover salaries and benefits next year and has started the year out with an across the board freeze on salary adjustments or reclassifications until August. They have indicated that they will require that the Bureau maintain a 15% vacancy rate all year and will stall hiring of vacant positions.

The Bureau continues to try to proactively address such factors as impacting birth outcomes and prenatal care utilization, such as violence, alcohol, substance abuse, tobacco, mental health, unintended pregnancy, and eliminating disparities between documented and undocumented pregnant women in access to services. The MCH Epidemiology Unit successfully mentored, a two year CSTE

fellow from Centers for Disease Control, as well as a two year Prevention Specialist from CDC as well. The CSTE fellow worked with the birth defects data and the CDC fellow assisted with the Comprehensive Assessment for 2005. While evidence-based interventions are increasingly requested, there are few resources to evaluate the impact of programs.

The Family Planning Program received a continued federal grant in FY2004 to support reproductive health services in the state. The initiative consists of increased funding to provide services in the Bernalillo Detention Center. That clinic has proven very effective in screening and treatment for STD's as well. The need for safety net programs has not diminished in the face of Medicaid budget deficits. The High Risk Prenatal Care fund which uses state funds to serve undocumented immigrants has far outstripped current resources.

B. BUDGET

B. Budget

The Federal support received from the MCH Block grant complements the State's total efforts to optimize services to the MCH population. In the 2006 federal grant budget, the amounts allocated to services for children and adolescents as well as children with special health care needs are higher than the required percentages, yet lower than FY2005. The amount allocated toward services to children and adolescents represents approximately 48% of the total MCH federal budget. The amount allocated toward children with special health care needs represents 39 percent of the federal budget. The remaining amount of $1,257,225 allocated for women, represents only 12 percent of the federal budget. Only 1% of the federal budget is expended on administration. Overall, the amount allocated toward Children and Adolescents, including the state funding equals 48 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 35 percent. The amount spent on mothers represents 15 percent of the entire budget. This, however, is changing currently as all resources previously spent for prenatal care media campaigns have been shifted to the High Risk Prenatal Care Fund. In addition, other resources are being sought to fill this need. The year has been spent analyzing current budgets across Title V programs. From FY2003 to the proposed budget for SFY2005 (state year), the Family Health Bureau has sustained an overall $384,426.00 cut in state MCH funding. Chances are that the Public Health Division will have to increase the FY2005 budget to provide at least as much as it provided in FY2004 during midyear budget review. This presents a problem relative to the software used to report the grant. Often, the Public Health Division will allocate a cut to the Title V budget initially, only to amend the budget midyear to meet the need for services. Seldom can the Title V Program operate within 10 percent of the original budget.

The summary budgets are an aggregation of all of the Organization Codes (programmatic financial accounts) that relate to Maternal and Child Health. These Organization Codes are program specific: e.g., Maternal Health, Title V /2005/ Adolescent Pregnancy Prevention/Family Planning, Child Health, Adolescent Health/Youth Development, Children's Medical Services, etc. Each Organization Code is allocated funding showing the federal/state distribution. The state match amount is considerably greater than the required three state dollars to four federal dollars and is also greater than the 1989 Maintenance of Effort amount of $3,087,900.

The state match is almost entirely from appropriations from the state general funds; a very small amount is from third party payments. The federal percent of the budget is based upon the level of funding in New Mexico's share of the MCH Block Grant for FFY 2006. Budget expansions have not yet been submitted for 2007. Rejection of all of last year's requests is an indication that the Department is supporting only a flat budget this coming year, in spite of this, the Bureau will re-submit expansions for CMS services. Budget allocations are official for 2006 as submitted in this grant application.

While 1.8 million was first cut from the MCH County Council budget by this administration, the advocates restored the 1.8 million during the legislative session for the FY2005 state year. In addition, several counties received additional monies directly from the General Fund. The amount of $122,000.00 was appropriated to the county of San Miguel to start a home visiting program. Santa Fe County also has its own state funded home visiting program serving only that county. The Children Youth and Families Department may expend $500,000.00 in collaboration with DOH to offer expanded homevisiting in two pilot sites.

The Direct health services are targeted to those with low incomes or with limited access to services who are uninsured or underinsured. The administrative component, paid totally out of state funds is comprised of the Family Health Bureau Chief's budget and includes fiscal, program, and personnel management, systems maintenance, strategic planning, and advocacy.

The budget meets the target percentages for Preventive and Primary Care for Children , Children with Special Health Care Needs, and Administration (is totally paid out of general fund).

The Department of Health's accounting system contains defined accounting codes for revenues and expenditures in each specific component of the maternal and child health program. Budgets are detailed by these accounting codes and expenditures charged to each specific component. The Department maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.